



# **Urology Services Inquiry**

## **Oral Hearing**

**Day 11 – Thursday, 17th November 2022**

**Being heard before: Ms Christine Smith KC (Chair)**  
**Dr Sonia Swart (Panel Member)**  
**Mr Damian Hanbury (Assessor)**

**Held at: Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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**Gwen Malone Stenography Services**

1           THE INQUIRY RESUMED ON THURSDAY, 17TH DAY OF  
2           NOVEMBER, 2022 AS FOLLOWS:

3  
4           CHAIR: Morning, everyone. Mr. Haynes, welcome back.

5           MR. WOLFE KC: Good morning, Chair, Dr. Swart, 10:06  
6           Mr. Hanbury. I understand there is a petition  
7           gathering force and if I couldn't allow for a break at  
8           half eleven the petition will be presented, so we will  
9           break somewhere between twenty past and half eleven, if  
10          that's suitable, Chair. 10:06

11          CHAIR: Certainly suitable to us, yes.

12          MR WOLFE KC: Just recapping on a couple of pieces from  
13          yesterday, I called out a rogue reference when dealing  
14          with the very important Aidan O'Brien perspective, as I  
15          think I called it. Let me pull up the reference now, 10:07  
16          just so that we can do it full justice. It's at  
17          WIT-82597. Just for the record, while that's coming  
18          up, I called yesterday WIT-82957, so that, if you want  
19          to go back to that, anybody, that's where the problem  
20          arose. The point I was dealing with was, I had 10:07  
21          reflected, Mr. Haynes' view that there was a demand  
22          capacity mismatch and then I juxtaposed that with  
23          Mr. O'Brien's observations that the issues which arose  
24          in relation to his practice were inextricably linked to  
25          the inadequate system I was working within. So that's 10:08  
26          the point fully framed.

1           MR. MARK HAYNES CONTINUED TO BE EXAMINED BY MR. WOLFE  
2           AS FOLLOWS:

- 3
- 4       1   Q.   Moving from that, can I pick up with you, Mr. Haynes,  
5           just a couple of, I suppose, procedural points that           10:08  
6           I was dealing with yesterday and, upon reflection, I am  
7           not sure I fully bottomed them out with you. One was  
8           in relation to the Datix. We saw, I think it was in  
9           the context of Patient 102 where you had raised a Datix  
10          in connection with an MDM decision that had not been           10:08  
11          implemented concerning Patient 102. Ultimately, as  
12          I think I demonstrated, the processing to stop with  
13          a David Cardwell e-mailing Mrs. Corrigan with the  
14          instruction that she should speak to the Consultant  
15          involved, who we understand to have been Mr. O'Brien.           10:09  
16          Just in relation to a Clinician completing a Datix or  
17          an IR1 such as you did here, can you help us by  
18          stepping through what you understand the various parts  
19          of a process, either leading to a decision for an SAI  
20          on the back of the Datix, or not as the case may be.           10:09  
21          You fill it in; where does it go?
- 22       A.   My understanding it goes, it's within the Datix system,  
23           so it's a fully electronic system. It's not a piece of  
24           paper passed around. Once the Datix, IR, the Incident  
25           Report form is filled in that's picked up by a member           10:10  
26           of the Governance team, and David Cardwell would be  
27           part of that team. There's an initial screen of  
28           Incident Reports, because Incident Reporting system is  
29           used for a whole manner of things. Some of them can

1 be, say, a slip on a wet floor, that sort of thing, and  
2 some of them can be clinical concerns.

3 2 Q. Yes.

4 A. There's an initial screen that takes place in terms of  
5 the severity and there's an agreed grading system for 10:10  
6 severity of potential incidents, but also the type of  
7 incident in terms of where it then goes. For instance,  
8 a ward level incident of a slip on a wet floor would  
9 not come to the Incident Report screening that I'd sit  
10 on as an Associate Medical Director. There's 10:11  
11 a screening, if you like, out of those things that are  
12 felt to be part of different bits of, if you like, the  
13 Trust system, and there's a screening based upon the  
14 severity with then brought to the screening are those  
15 that are related to clinical practice and above -- I am 10:11  
16 going from memory, I think it's above a certain  
17 severity level.

18 3 Q. Yes. Sorry, I just lost it in my hearing. If they  
19 percolate up to a level where somebody in the  
20 Governance team thinks they should reach, did you say 10:11  
21 a Screening Committee?

22 A. It's a screening -- it's the team so it's Governance,  
23 member of the governance, the Assistant Director and  
24 the AMDs.

25 4 Q. Yes. 10:12

26 A. Yes.

27 5 Q. Just to be clear, I think you answered it clearly  
28 yesterday, but Patient 102, which variously described  
29 as a failure to issue correspondence but more

generally, a failure to implement an MDM decision to refer to Radiotherapy, delaying treatment for approximately 12 months, that should certainly have made it to the Screening Committee or the Incident Committee?

10:12

A. I would have thought so, yeah. It would be my view.

6 Q. Yes. Again, just a procedural type issue arising out of that case. You explained yesterday that, to the best of your understanding, this was a case where the MDM decision was for referral to Oncology?

10:13

A. For a direct referral to Oncology which means there should -- in that decision, there's a referral that should be created at the Multidisciplinary Team Meeting to go to Oncology.

7 Q. Yes. The question that spins out of that is, there's various people with jobs to do at MDM, so the Clinician, the treating Clinician would present the case at the MDM?

10:13

A. That's the case in some Multidisciplinary Team Meetings, it's not the case in Urology. In Urology, the Chair on the day of the meeting presents all the cases.

10:13

8 Q. Okay. If the consensus of the MDM is for a referral, and a direct referral as in this case, who holds the responsibility to ensure that the form is completed or the letter is issued to the people who should receive the referral? In other words, presumably the Cancer Centre in Belfast?

10:14

A. The outcome from the MDM is, you typically generate it

1 live at the time of the MDT, usually by essentially  
2 a live transcription from the Chair and annotated by  
3 the MDM Coordinator. The MDM Chair checks them and  
4 approves them before they are circulated. The direct  
5 referral itself is generated, it's my understanding, by 10:14  
6 the MDM Coordinator, and my memory of that SAI is that  
7 MDM direct referral was generated but then there was no  
8 record of it having then subsequently been received and  
9 therefore the patient didn't get an appointment.

10 9 Q. Yes. I think we are going to try to get access to 10:15  
11 those patient notes and associated notes to work  
12 through that process, but, for present purposes,  
13 I think that's helpful.

14  
15 We rounded off yesterday by considering the case of 10:15  
16 Patient 93, you will recall, which was, not to put too  
17 fine a point on it, a failure of Triage, and we worked  
18 through how you e-mailed through your observations in  
19 relation to that, and they eventually reached  
20 Mr. Young. Before that, chronologically the case of 10:16  
21 patient 93 appears to have arisen in or about August  
22 2016. In January of that year, you were doing a clinic  
23 when you saw a Patient 10 -- just orientate yourself to  
24 her -- and you raised a Datix or an IR1, which we can  
25 find at PAT, I think it's at three zeros, if not 10:16  
26 4 zeros, 51.

27  
28 Highlight that for me, just the main text.  
29

1 We can see, Mr. Haynes, just at the bottom of the  
2 screen, that you are the reporter, 6th January 2016.  
3 This was a case where you were concerned about a number  
4 of issues, it appears. I think, judging by the text,  
5 you were concerned about the quality, or the accuracy 10:18  
6 is perhaps a more honest way of putting it, of the  
7 radiology report in respect of this lady, and you  
8 highlight in the middle of that text that the patient  
9 was referred to the Urology Department on 29th October  
10 2014 for assessment. Then you go on to say that the 10:18  
11 referral was not Triage'd on receipt. Essentially,  
12 there were two issues that went forward from that  
13 Incident Report and were considered as an SAI review  
14 under the charge of, I think, Mr. Glackin; is that  
15 correct? 10:19

16 A. Yeah.

17 10 Q. Was this the first case that had come across your desk  
18 or your surgery with a specific problem flowing from  
19 a failure to conduct Triage?

20 A. I think it was the first time I'd noticed that there 10:19  
21 was a failure to Triage and, as it says on the Incident  
22 Report forms, the report is fact rather than opinion,  
23 so I haven't put in any thought there. I do recollect  
24 that clinic, I recollect many of my consultations with  
25 the family. In preparing for the Clinic, I tended to, 10:20  
26 before turning up to Clinic, look at the patients I was  
27 due to see, very much in a planning and preparation for  
28 the Clinic. This was a new patient Clinic where we had  
29 the ability to get ultrasound scans, we could do

1 flexible cystoscopies, we could do prostate biopsies  
2 where needed. I tended to before attending the Clinic  
3 put together a quick review of the patients who were  
4 coming so that I could give the, if you like,  
5 a heads-up to the nursing staff in Clinic that day as 10:21  
6 to what would be required during that Outpatient  
7 Clinic. In that initial review of Patient 10's  
8 referral and then looking at the scan, it was apparent  
9 to me that the scan report of the MRI did not fit with  
10 the reason the scan was requested. As I said, there 10:21  
11 was a report of two cysts, I think, in the kidney, one  
12 at the upper pole, and one at the lower pole, and the  
13 MRI report only commented on one of them, which caused  
14 me to have a look at the scans myself. Again, my  
15 memory is I actually liaised with a Radiology colleague 10:21  
16 before the Clinic saying I think there's an issue been  
17 missed here in this report, this is what I am going to  
18 need to get in terms of up-to-date scans. In that  
19 review, and when I saw the patient, it was apparent to  
20 me that the referral letter itself had not been triaged 10:22  
21 as well. As I say, the Incident Report is fact and not  
22 opinion, but my opinion at that time, and I would  
23 maintain it now, is that there was an opportunity that,  
24 if, at Triage, someone had spotted the same  
25 inconsistency between the reason the MRI was requested 10:22  
26 and the MRI report, it could have been detected that  
27 there was an issue with that report, and actually,  
28 potentially, there may be a more significant finding  
29 and, therefore, the patient might have needed upgrading

1 from Routine.

2 11 Q. Yes. You use the word opportunity there. I think  
3 that's also the word used by the SAI Review Team when  
4 they came to report later that year or early next year.  
5 Let me just see if I can find that. If we can go to 10:23  
6 PAT-00007 in that series? We can see just in that  
7 fourth paragraph there, it says:

8  
9 "The Review Panel agree that in relation to the  
10 patient, the opportunity to upgrade the referral to red 10:23  
11 flag was lost by the omission of Triage resulting in  
12 a 64 week delay to diagnosis of a suspicious renal  
13 mass. "

14  
15 Mr. O'Brien, in his defence, argued that even if this 10:24  
16 had been triaged by him, he would still have treated it  
17 as routine because he would not have seen the problem  
18 here on the Radiology report. You emphasise the word  
19 "opportunity", as does the Review Team. Does that  
20 suggest that what you are saying is that not everyone, 10:24  
21 not every Clinician in the time available to Triage  
22 would necessarily have spotted the problem, but if you  
23 had triaged, there was at least a chance, or an  
24 opportunity, that the problem could have been spotted?

25 A. Yes. You know, it's an opportunity, that I'd reflect 10:25  
26 that I'd identified it on a relatively quick review of  
27 the referral letters in advance of that Clinic, that  
28 would not have been a huge amount different in terms of  
29 what I was thinking as to what I would have done at

1 Triage of similar referrals.

2 12 Q. In many respects, I suppose, albeit extremely  
3 unfortunate and traumatic for this patient, but in many  
4 respects the bigger point is that the failure to do  
5 Triage in any case for the purposes of reviewing the 10:25  
6 GP's designation, is the bigger issue; it's the broader  
7 issue affecting the Service and affecting, potentially,  
8 any patient coming into the Service on a referral?

9 A. Yeah. If, for whatever reason, the condition the  
10 patient is being referred to, is referred on at the 10:26  
11 wrong urgency category, and that Triage process doesn't  
12 happen, then the patient will continue on the pathway  
13 for the referral category, and in this case that was  
14 routine.

15 13 Q. It was this kind of discovery in a live case such as 10:26  
16 this that became, I think I've seen it described as the  
17 Index Case, this kind of discovery was to give rise to,  
18 in 2017, a rather urgent Lookback across a number of  
19 cases from the period '15, '16, to see what else could  
20 be discovered in other cases arising out of failure to 10:27  
21 Triage?

22 A. Yeah. My recollection of the steps that went through  
23 is the SAI Panel, as you say which was chaired by  
24 Mr. Glackin, identified or confirmed that that referral  
25 hadn't been triaged. They then asked the question were 10:27  
26 any other referrals from that same week not triaged,  
27 and identified that there were some other referrals  
28 from that week not triaged. That led on to events  
29 where a significant number of un-triaged referrals were

1 in a filing cabinet in Mr. O'Brien's office, and from  
2 there, all of them un-triaged referrals were then  
3 triaged effectively late by the rest of the Consultant  
4 team through early 2017.

5 14 Q. I'm going to come, just in the right order, a little 10:28  
6 later this morning, the SAI arising out of the five  
7 patients which you participated in. You were the  
8 Urologist participant in that review.

9  
10 Just before we move away from that case, that was 10:28  
11 January '16. You'd also, as we noted yesterday, had  
12 the failure of Triage in Patient 93's case, which was  
13 later in 2016. Can I just pick you up on something  
14 you've said in your witness statement? If we could  
15 have up on the screen WIT-53952? If we could just 10:29  
16 look at 73.6 of your statement. Within this paragraph  
17 you are talking about the period after becoming  
18 Associate Medical Director and you are saying:

19  
20 "The absence of an induction process or handover for 10:30  
21 incoming AMDs was also a factor" in the difficulties  
22 you faced.

23  
24 You say: "For example, it was only after the  
25 identification of the un-triaged referrals in 2017 that 10:30  
26 I was made aware that this had been an issue previously  
27 with Mr. O'Brien."

28  
29 That is seeming to suggest that it was only after you

1 had become AMD that you became aware of the issue of  
2 a lack of Triage?

3 A. As I read that paragraph, I think, as I made in my  
4 corrections yesterday, I'd made a date error in terms  
5 of as I wrote my statement and had put that from my 10:30  
6 memory it was just after I became AMD that this  
7 happened, which was wrong. I actually became AMD in  
8 October 2017, but I think the general point I am making  
9 within that statement is that it was only after that  
10 2017 period of finding the lack of Triage that I was CD 10:31  
11 for Surgery and Trauma and Orthopaedics at the time, so  
12 Clinical Director at the time, but myself and Colin  
13 Weir, who was the CD for Urology, hadn't been made  
14 aware through anything that there had been a historic  
15 issue with lack of Triage by Mr. O'Brien. As there's 10:31  
16 been other people's statements, there had been  
17 a history of that same issue being picked up  
18 previously.

19 15 Q. The issue of failure to triage on time was,  
20 nevertheless, an issue that you were bound to have been 10:32  
21 aware of more generally, even if it wasn't associated  
22 in your mind necessarily with Mr. O'Brien? Let me  
23 orientate you a little bit further on this point. If  
24 we turn to TRU-274344 on the screen please. Just  
25 scroll down. Yes. 10:33

26  
27 In late 2014, you are in post just over six months.  
28 Martina Corrigan is writing to all of the Urologists in  
29 the team and she is saying:

1  
2 "Please see attached ... 206 outstanding Triage letters  
3 on this list" and she is highlighting you will see the  
4 longest outstanding is 263 days, and if we scroll down  
5 we will see the spreadsheets she attaches to this. Do 10:33  
6 you remember such an e-mail?

7 A. I don't recall it. I'm in the circulation list so  
8 I would have received it.

9 16 Q. Yes. I wouldn't necessarily have expected you to  
10 recall receiving this specific e-mail. I suppose the 10:34  
11 general point is that this is an example added to the  
12 two cases that you pick up on and report in association  
13 with Mr. O'Brien, that this is an example of, can  
14 I suggest to you, a general awareness that Mr. O'Brien  
15 wasn't triaging? 10:34

16 A. I think it points to an awareness that there was Triage  
17 that wasn't happening. I'm not sure in that e-mail  
18 that it's identified as a single practitioner or  
19 multiple practitioners. When I raised the Patient 10  
20 IR1, I haven't identified who hasn't triaged, because 10:35  
21 I wouldn't necessarily know who that referral letter  
22 has been passed to. There was an awareness that  
23 evidently some patients were not being triaged. At  
24 that time, triage was paper-based, and pieces of paper  
25 passing around a hospital can and do go missing. It's 10:35  
26 not kind of dismissing it but there are other reasons  
27 why a paper-based Triage can go missing as well as it  
28 being down to an individual failure. You mentioned  
29 late triage. I think there's a difference between late

1 triage and no triage. No triage is not returning it at  
2 all, which is very different to returning it a week or  
3 two later.

4 17 Q. Yes. The cases that we've looked at, the Patient 10  
5 and Patient 93, they were examples of no Triage, the  
6 Triage wasn't returned?

10:36

7 A. Yeah.

8 18 Q. And not then followed up by the system?

9 A. Yeah.

10 19 Q. In other words, the default arrangement kicked in and  
11 the patients were allocated a place in the waiting list  
12 in accordance with the General Practitioner's  
13 designation?

10:36

14 A. Yes.

15 20 Q. These are examples of early concerns that you were  
16 picking up. You are just a year or 18 months in your  
17 role at the Southern Trust. One of the other issues  
18 that you appear to have picked up and expressed concern  
19 about, is the question of whether private patients of  
20 Mr. O'Brien were the subject of some form of advantage  
21 when it came to the allocation of treatment. Can  
22 I refer you to an e-mail you've appeared to have sent  
23 in May 2015?

10:36

10:37

24  
25 If we can up on the screen, please, WIT-54107?

10:37

26  
27 This is an e-mail from you to Michael. Michael Young  
28 is the Clinical Lead in Urology, is that correct? And  
29 Martina Corrigan, who at that time was the Head of

1 Service Urology. You are saying here:

2  
3 "I feel increasingly uncomfortable discussing the  
4 urgent waiting list problem while we turn a blind eye  
5 to a colleague listing patients for surgery out of date 10:38  
6 order usually having been reviewed in a Saturday  
7 non-NHS clinic. On the attached total urgent waiting  
8 list there are 89 patients listed for an urgent TURP,  
9 the majority of whom will have catheters in situ, they  
10 have been waiting up to 92 weeks. 10:39

11  
12 However on the ward this week is a man ... who went  
13 into retention on 16th March" --

14  
15 That's just a little over two months earlier. 10:39

16  
17 -- "failed a TROC on 31st March 2015. He was seen in  
18 private clinic on Saturday 18th April and admitted with  
19 a view to surgery on 27th May."

20 10:39  
21 You call that immoral. This was a private patient of  
22 Mr. O'Brien; is that correct?

23 A. That's where he had been seen on the Saturday, as  
24 a private patient.

25 21 Q. How did you come across the issue? 10:39

26 A. In our practice working as Urologists of the week we  
27 would do a ward round of all of the inpatients under  
28 the care of Urology, so not just individual consultants  
29 but every Elective and Emergency admission. In doing

1 my ward round, I reviewed him on the ward round and, in  
2 reviewing his notes in seeing him, the private letter  
3 detailing the private consultation from the Saturday  
4 was present, and the timings of his attendances in  
5 retention and for his trial removal of catheter were  
6 also present. 10:40

7 22 Q. Yes. Why did you consider it immoral what was  
8 happening?

9 A. As I have said in the letter, the Service this patient  
10 got is what we would have aspire to deliver to 10:40  
11 everyone, but at the same time as this man got an  
12 aspirational level of Service, there were patients in  
13 the same situation with catheters in awaiting the same  
14 operation for up to 92 weeks. What we had was someone  
15 who had, through whatever means, been able to seek 10:41  
16 private input. His surgery had been brought forward  
17 ahead of anyone else on the waiting list. While that  
18 patient may well have been distressed with his  
19 catheter, our secretaries, then and now, will  
20 continually receive contact from GPs and patients who 10:41  
21 are distressed with catheters who have been waiting on  
22 our waiting list. To, if you like, expedited this  
23 patient's treatment while the patient waiting 92 weeks,  
24 perhaps miserable, perhaps suffering every day, but  
25 patiently waiting their turn, it just disadvantages, if 10:41  
26 you like, the silent sufferer, the man who is just  
27 accepting a Service which is not able to deliver  
28 treatments in the timescale that the patient would like  
29 and we would like, but is accepting that and patiently

1           waiting his turn.

2    23   Q.    Have you considered whether, in any of the cases that  
3           you have come across where you believe that there's an  
4           immoral approach to it, have you considered whether, on  
5           clinical grounds, the prompt attention given to those   10:42  
6           patients could be justified?

7           A.   Without conducting a Clinical Review of all of the  
8           other patients on the waiting list for the same  
9           condition and assessing their level of symptomatology  
10          and their suffering, I don't know how you can make   10:42  
11          a fair justification for that patient at better,  
12          greater need than a patient you don't know about.

13   24   Q.    Yes, but if Mr. O'Brien, in knowing this particular  
14          patient, takes the view that there are clinical reasons  
15          which would justify a prompter approach than for other   10:43  
16          patients, that's justifiable, is it not, on clinical  
17          grounds?

18          A.   The only reason for knowing this patient's condition is  
19          because he's had the means, or whatever, to seek  
20          private input. The patient who is at home, silently   10:43  
21          suffering, who perhaps doesn't know how to access that,  
22          perhaps hasn't got the means to access that, doesn't  
23          get their needs assessed and is disadvantaged.

24   25   Q.    Are you suggesting that the appropriate approach here  
25          would have been to put the patient on the normal Trust   10:43  
26          waiting list and take your time before reaching the  
27          top, or to suggest, in the alternative, that he takes  
28          his medical problem into the independent or private  
29          sector and is treated there?

1 A. Yeah. My approach to when patients contact my  
2 secretary in this same situation, is you typically  
3 advise them and the GP of the issues with our waiting  
4 list, but that, unfortunately, I have to manage  
5 patients chronologically which means I won't be 10:44  
6 bringing their treatment ahead of someone who has  
7 waited longer, but equally I won't bring someone ahead  
8 of them who has waited shorter. Also, where patients  
9 are distressed, I will also arrange a Clinic Review to  
10 discuss this directly with them and work with our 10:44  
11 colleagues in the Community Continence Team, our  
12 Primary Care colleagues and our Clinical Nurse  
13 Specialist colleagues to see what measures we can put  
14 in place in the interim to alleviate the problems the  
15 patient is getting. 10:45

16 26 Q. Just scroll up a little. Scroll up so I can see the  
17 last paragraph.

18

19 You say: "The behaviour needs to be challenged and  
20 a stop put to it" I think that should read. You say 10:45  
21 you are: "... unwilling to take the long waiting urgent  
22 patients while a member of the team offers presentation  
23 NHS treatment to patients he sees privately. I would  
24 suggest that this needs challenging by a retrospective  
25 audit of waiting times/chronological listing and an 10:45  
26 honest discussion as a team..."

27

28 Do you know if your suggestion of a scientific audit to  
29 assess the extent of this problem was conducted at that

1 time?

2 A. Not at that time, to my knowledge.

3 27 Q. If we scroll up to page 254106?

4

5 At the tail-end of the year, some six months later, you 10:46

6 are writing again to Mr. Young and Mrs. Corrigan and

7 you have entitled this e-mail "queue jumpers". Is this

8 essentially the same subject?

9 A. Yes.

10 28 Q. Before we get into the e-mail, why are you writing 10:47

11 again?

12 A. Because once again, as I say in that top paragraph:

13

14 "As I have been through our inpatients in preparation

15 for taking over the on-call today have once again come 10:47

16 across examples of this behaviour continuing".

17

18 I am taking over as urologist of the week and I have

19 identified two patients there who have had very short

20 waiting times and been brought in for surgery, having 10:47

21 been seen privately.

22 29 Q. Just let me see if I can see Mr. Young's response on

23 this. No, I may not have it. I will refer to it maybe

24 later, if necessary. This is the tail-end of 2015.

25 Again, is the problem, as you see it, resolved at that 10:48

26 point?

27 A. Absolutely not, it's still happening.

28 30 Q. Okay. Are you aware of any initiative undertaken,

29 either by Mr. Young or by Mrs. Corrigan, to address it?

1 A. No.

2 31 Q. Do you receive any feedback at all?

3 A. Not that I recollect.

4 32 Q. Again, this is before you take on a managerial role,  
5 you don't address it with Mr. O'Brien? 10:48

6 A. No.

7 33 Q. why not? why would you not take it up with  
8 a colleague?

9 A. As I said yesterday, the awareness, as it were, of the  
10 people around Mr. O'Brien and, in general, experience 10:49  
11 of him, I think I said yesterday him being a challenge  
12 to challenge. Essentially, a fear of taking it up.  
13 Mr. Young had a long working relationship with  
14 Mr. O'Brien and, in general, would have -- the reason  
15 I escalated it to him in his position of Lead is part 10:49  
16 in that he was Clinical Lead at the time and in, part,  
17 that he has that longer working relationship, so his  
18 ability or, if you like, his seniority on a level with  
19 Mr. O'Brien to challenge it, would have been, I guess,  
20 more effective, I felt, than me as a new kid on the 10:50  
21 block.

22 34 Q. In December of the next year, you wrote a further  
23 e-mail on the subject. If we could have up AOB-01300?  
24 Scroll down, please. Thank you.

25 10:50

26 23rd December 2016 you are writing to Ronan Carroll.  
27 Ronan Carroll, remind us, was the Assistant Director  
28 within Acute?

29 A. Yeah.

1 35 Q. And management of private patients, is that PP?  
2 A. Yes.

3 36 Q. And non-chronological listing. Can you recall the  
4 context in which you are writing this?  
5 A. Essentially I have come across again a patient who has 10:51  
6 had a short wait from a private consultation to a TURP  
7 on an NHS waiting list. At that time, so this is  
8 December 2016, this is a point in time where the  
9 non-triage has been identified, Dr. Wright is engaged  
10 in and involved in issues surrounding Mr. O'Brien, and 10:51  
11 this is me that this issue should be looked in as part  
12 of that overall look into Mr. O'Brien's practice.

13 37 Q. Yes. You are right to say in terms of the chronology  
14 of events, this is reaching the point when the Trust is  
15 about to make a decision, or has maybe just made 10:52  
16 a decision, that an MHPS investigation was to be  
17 conducted. Are you feeding into that specifically  
18 because you have been told that, or how are you  
19 orientated to what Dr. Wright, as the Medical Director,  
20 is doing? 10:52

21 A. I just had conversations with Dr. Wright around  
22 concerns about Mr. O'Brien, and, as the last line says,  
23 the question I was asking of Ronan Carroll was did  
24 I think this should be fed into the overall  
25 investigation. 10:52

26 38 Q. Yes. We know that it was. Let me have your  
27 observations, if you will. You saw this as a problem.  
28 You saw it as immoral. You saw that essentially  
29 patients on the waiting list for years were being

1           cheated? I see you nodding. You agree with that?

2           A.   Disadvantaged.

3   39   Q.   Disadvantaged. You believed, and Mr. O'Brien has his  
4           own perspective on this, but, to keep it at its most  
5           neutral, you believed that there was an experienced   10:53  
6           clinician breaking the rules, and there were rules, in  
7           respect of the treatment of private patients. You seem  
8           to be observing that those in managerial positions  
9           didn't grapple with it, or at least if they grappled  
10          with it, they didn't do it successfully?   10:53

11          A.   Yeah. I mean whether rules or not, I am fairly clear  
12          in my thoughts on it. It's just not right. You don't  
13          need a rule to tell you it's not right.

14   40   Q.   What does it say about the Governance of this issue at  
15          that time as it was implemented or ought to have been   10:54  
16          implemented by management on both the operational and  
17          medical side?

18          A.   It was, at best, ineffective. Certainly, I think it  
19          probably illustrates -- you've asked me why I didn't  
20          approach it. I suspect that the same, if you like,   10:55  
21          fear element in terms of challenging Mr. O'Brien  
22          existed for the likes of Martina Corrigan and others  
23          who were challenged with challenging his practice. As  
24          a result, the easier route of essentially allowing  
25          things to continue may have happened.   10:55

26   41   Q.   If I could have up on the screen, please, WIT-53932?  
27

28           In this section of your statement, and again we are  
29           still at this earlier phase of your career with the

1 Southern Trust. What you are reflecting is that  
 2 Mr. O'Brien had different ways of working compared with  
 3 others. This is 61.1. It was apparent that many of  
 4 these were embedded in his working patterns and widely  
 5 accepted across the Trust as "his way".

10:56

6  
 7 You go on at 61.2 to give an example of the lack of  
 8 Clinical information, which we have seen in one of the  
 9 incidents we looked at yesterday. You talk about the  
 10 voicing of concerns would have occurred during informal  
 11 conversations and within Departmental meetings,  
 12 including with the Head of Service but, as you observed  
 13 a moment or two ago, in the context of private  
 14 patients, the managerial response to this was at best  
 15 ineffective. Amongst colleagues, that's yourself,  
 16 Mr. Young, Mr. O'Donoghue by this point and  
 17 Mr. Glackin, I think Mr. Suresh as well -- he left  
 18 when? In 2016, I think?

10:57

10:57

19 A. I can't remember.

20 42 Q. But amongst colleagues you talk about informal  
 21 meetings. Was there any attempt on the part of the  
 22 Urology team as a group, the group of people who  
 23 collaboratively are delivering this Service and who  
 24 are, no doubt, impacted by these behaviours that you  
 25 have outlined, was there no challenge coming from the  
 26 group?

10:58

10:58

27 A. As I say, it was certainly discussed within meetings.  
 28 I don't have documented recollections of it but I have  
 29 included in my statements, I certainly recall when

1 a discussion about contemporaneous GP letters came up  
2 in one such meeting, Mr. O'Brien expressing an opinion  
3 that the only two people that needed to know the  
4 outcome of the consultation was him and the patient as  
5 his justification for why nothing else was needed. 10:59

6 43 Q. Does that suggest that, however frequently issues were  
7 raised with him and he rebuffed the challenge and  
8 nothing more was done, it was -- was it a group shrug  
9 of the shoulders, that's just Mr. O'Brien and we can't  
10 do much about it? 10:59

11 A. I think we had attempted to let him know our concerns,  
12 you know, even to the point of where if we were doing  
13 Clinics to see long waiting patients who had been seen  
14 by him before, we weren't able to see as many as we  
15 might see if we were doing a long waiting list of 11:00  
16 patients in Clinic who had been under the care of  
17 someone else because we didn't have the documented  
18 decision-making processes leading up to that, that we  
19 could quickly review, and so the process of reviewing  
20 patients took longer. Did we collectively as a group 11:00  
21 shrug our shoulders? I think I certainly continued --  
22 well, I certainly had raised concerns and I did raise  
23 concerns where it impacted.

24 44 Q. You were, in raising concerns, looking to the systems  
25 and Management to take those concerns seriously and 11:00  
26 make appropriate challenge and escalation if the  
27 challenge was rebuffed?

28 A. Yeah. We, as a group, had made an informal challenge  
29 of, you know, this is an issue for us.

1 45 Q. Yes.

2 A. And it was rebuffed.

3 46 Q. Just moving through your statement a little and go to  
4 53948. Again, let me just step through this relatively  
5 quickly. At 69.7 on that page, you are reflecting upon 11:01  
6 the fact that Mr. O'Brien failed, from your  
7 perspective, to use the support services that were  
8 available to him, that he undertook many of the  
9 administrative tasks that otherwise would be performed  
10 by a secretarial bank. How were you able to observe 11:02  
11 that?

12 A. He would recount to us how long it took him to organise  
13 a planned theatre list because of the time taken to  
14 phone patients and check that they were available to  
15 come in, and the like. Where the process that others 11:02  
16 would use would be to identify the potential patients  
17 for a theatre list, and our secretaries would do the  
18 contacting of patients, the arrangements of times to  
19 come in, and the like, the arrangement for transport  
20 where required. He was spending time, to my 11:02  
21 observation, doing jobs that my secretary did for me.

22 47 Q. Moving down the page to 69.8, you make the point that  
23 he complained of the number of interactions or  
24 inquiries that he was having to deal with from the  
25 Primary Care Sector. Your response to that is that the 11:03  
26 absence of dictated letters to the General  
27 Practitioners to tell them about their patients would  
28 have addressed that kind of problem?

29 A. Yeah, and, as subsequently came to light with regards

1 cancer patients, the involvement of Clinical Nurse  
 2 Specialists. If everyone involved in someone's case  
 3 has a clear record of what the plan is, then you don't  
 4 get an Inquiry as to what is the plan, and so it can  
 5 take some of that, then inquiries away. Particularly 11:04  
 6 with regards cancer patients, many of the uncertainties  
 7 or queries about cancer patients, for me, for instance,  
 8 would come directly to the key worker through the  
 9 contact number for the Clinical Nurse Specialist. So,  
 10 the workload of patient and GP inquiries can be 11:04  
 11 significantly reduced by ensuring contemporaneous  
 12 correspondence is available to all those involved in  
 13 care, and patients have got access to the support  
 14 systems and services that are available for them to be  
 15 able to contact with their inquiries. 11:04

16 48 Q. Were you aware at the time, I mean 2014/15, at any time  
 17 prior to the 2020 SAIs discovering, apparently, for the  
 18 first time, Mr. O'Brien's failure as it was reported to  
 19 use Cancer Nurse Specialists or Key Workers in the  
 20 treatment of cancer patients? 11:05

21 A. Not that I recollect.

22 49 Q. Your observation here is with the benefit of that  
 23 revelation?

24 A. Yeah.

25 50 Q. It wasn't obvious to you as a practitioner working 11:05  
 26 within that Service that, as the reviewers in those  
 27 2020 SAI cases concluded that there was a failure to  
 28 use that resource, whereas other practitioners were  
 29 using that Nursing resource?

1 A. No, that wasn't apparent to me. As I have said in the  
2 preceding paragraph, it was apparent that there were  
3 other resources that he wasn't making use of.

4 51 Q. But not that one?

5 A. But not that one. 11:06

6 52 Q. Just on this page, you deal with the DARO process.  
7 I am going to come back to that in a short while. You  
8 raise a specific issue at the bottom of that page. If  
9 we can scroll down, please, to 69.10? It concerns an  
10 issue that you say arose out of a coroner's verdict in 11:06  
11 October 2015, seemingly a coroner's verdict that was  
12 unrelated to the Trust?

13 A. No, not related to the Trust.

14 53 Q. The issue that arose out of it was a proposed change to  
15 regional policy in the context of the surgical 11:06  
16 management of endoscopic issue resection. Was this  
17 a fluid management type issue or hyponatraemia type  
18 issue?

19 A. It related to the fluid used during endoscopic  
20 resection, as it describes. Historically transurethral 11:07  
21 surgery was performed using glycine as a fluid medium  
22 and monopolar diathermy. That, in itself, has long  
23 been recognised in Urology to carry a risk of  
24 absorption of that fluid, and absorption of that fluid  
25 in significant quantities can lead to problems of fluid 11:07  
26 overload, hyponatraemia, and also glycine toxicity,  
27 so-called TUR syndrome. The circular related to  
28 a patient death following a resection, not in Urology,  
29 from a TUR syndrome. The circular referred to newer

1 technology which had been around for a number of years  
2 by this point, which is using bipolar diathermy.  
3 Rather than monopolar, using bipolar technology where  
4 the fluid medium is normal saline. For want of  
5 a better term it, it's salt water.

11:08

6 54 Q. Yes.

7 A. While using that normal saline as your fluid medium  
8 doesn't takeaway the risk of fluid absorption, it's  
9 absorption of fluid with a normal level of sodium and  
10 without glycine, so without the risk of glycine  
11 toxicity, so the risk of patient morbidity related with  
12 that fluid absorption is less.

11:08

13 55 Q. Thank you for that background. The issue that you  
14 raise -- just if we scroll up a little -- is that  
15 a good deal of work was done as a team to examine this  
16 proposed policy change. It seems what you are saying  
17 is, at the end of it, Mr. O'Brien expressed the view  
18 that he would be continuing to use monopolar resection  
19 and glycine and would not comply with the policy?

11:09

20 A. Bipolar resection, the equipment is very similar to  
21 monopolar resection, but the way you resect is slightly  
22 different. You tend to move your electrodes slightly  
23 slower, so there's a slight change in the way you  
24 operate with it. Mr. O'Brien expressed a view that it  
25 was the equipment, bipolar resection was inferior to  
26 monopolar resection and therefore he was going to  
27 continue using monopolar resection.

11:09

28 56 Q. Why are you telling us about this? Why was it  
29 significant in terms of your impression of Mr. O'Brien?

1           A.    To me, as I was reflecting on things completing my  
2                Section 21 statement, it brought to me a recognition  
3                that perhaps it was illustrative of an approach where  
4                Mr. O'Brien was, I have said a challenge to challenge,  
5                he was resistant to an external recommendation of           11:10  
6                changing his practice to an alternative way of  
7                practice.

8    57   Q.    He wasn't challenged on this at the time, was he?

9           A.    I don't recall any challenge at the time. I do know,  
10                from subsequent conversations with Anaesthetic team           11:11  
11                members who would have worked with Mr. O'Brien on his  
12                theatre list that mitigations recognising that he  
13                continued to use monopolar resections, such as regular  
14                monitoring of blood sodium during resection, were put  
15                in place, recognising that he continued to use glycine           11:11  
16                as a resection medium.

17   58   Q.    In terms of these gathering impressions of Mr. O'Brien  
18                and your clinical experience of the impact of what you  
19                have described as some of his shortcomings on your  
20                practice and on the patients that you were treating,           11:12  
21                you are credited by Mrs. Corrigan and Mr. Mackle as  
22                creating the context or contributing to the context in  
23                which, by the end of 2015 and into early 2016,  
24                a decision was made to speak to Mr. O'Brien in order to  
25                see if an improvement could be obtained in his           11:13  
26                practice. Let me just, for the record, open some of  
27                those observations.

28

29                If we go to WIT-39888. Just scroll down, please. No,

1 it doesn't appear to be the right reference. Could we  
2 try WIT-11783, and if we go to paragraph 122?

3  
4 This is Mr. Mackle's response to the Section 21, and he  
5 says, just at the bottom of that paragraph:

11:14

6  
7 "Following the changes to the booking of Outpatient  
8 referrals I was not made aware of any delays in Triage  
9 and it was only the raising of concerns by Aidan  
10 O'Brien's colleagues, while performing Validation  
11 Clinics in late 2015, that ultimately led to the  
12 investigation into his practice."

11:15

13  
14 It is the case that when you and Mr. Donoghue took up  
15 post, he in the summer of 2014, you were given the  
16 task, while you generated your own group of patients,  
17 to review some of the longer waiters on Mr. O'Brien's  
18 review list?

11:15

19 A. Yes. At the point of taking up post we didn't have  
20 patients awaiting review specifically. There would  
21 have been backlogs from previous consultants, so when  
22 I took up post I, if you like, inherited Mr. Pahuja,  
23 who had left the post, patient waiting list. I would  
24 have seen patients that would have been planned for  
25 review by Mr. Pahuja, and part of that included taking  
26 long waiting patients from our colleagues as well.

11:15

27 59 Q. In that process, it seems that you spotted some of the  
28 difficulties we've outlined earlier and communicated  
29 your concerns to Mrs. Corrigan and Mr. Mackle?

11:16

1           A.    Yeah.  As I mentioned earlier, we had recognised as  
2                colleagues that reviewing long waiting patients of  
3                Mr. O'Brien's where there was, perhaps, no  
4                correspondence was more of a challenge and took longer  
5                and, as a result, the clinic template, the numbers of   11:16  
6                patients or the time per patient that was assigned was  
7                adjusted to reflect that.

8   60   Q.    Did you go to Mr. Mackle as well or was it  
9                Mrs. Corrigan reporting to Mr. Mackle?

10          A.   I don't have a clear recollection.  I think it would   11:17  
11               have been a conversation that we would have had about  
12               them specific clinics but I don't have a specific  
13               recollection about it.

14   61   Q.    It would appear, at least from what they are saying,  
15               that this led to a meeting with Mr. O'Brien in March   11:17  
16               2016 that called upon him to address some of these  
17               issues and then, by the end of that year, 2016, the  
18               MHPS investigation was about to be launched.  At that  
19               time, running simultaneously with those conversations,  
20               was the investigation into the Patient 10 SAI.  Into   11:18  
21               the following year then, you and your colleagues in the  
22               team were asked to do some further work in relation to  
23               the Triage issue; isn't that right?

24          A.    Yeah.  So into 2017, we triaged for the first time  
25               those referrals that were in the filing cabinet.   11:18

26   62   Q.    As a result of that, a number of cases were identified  
27               as being cases that, had they been triaged in 2015 and  
28               2016, they would have been red-flagged, or they ought  
29               to have been red-flagged?

1 A. They met criteria for a red-flag referral, and so we  
2 upgraded them.

3 63 Q. After the break, I think we'll start into looking at  
4 that SAI concerning the five cases. If that's  
5 a convenient time?

11:19

6 CHAIR: Yes. So let's reconvene then at 25 to 12.

7

8 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

9

10 MR. WOLFE KC: I was dealing earlier this morning with  
11 the issue of private patients and I took Mr. Haynes  
12 through a couple of e-mails that he had issued, ending  
13 with one which he sent to Mr. Young and Mrs. Corrigan  
14 at the tail end of 2015, November 2015. I didn't bring  
15 you to Mr. Young's response to that e-mail. I don't  
16 propose opening it, now but just, for your note, you  
17 will find his response at TRU-274504.

11:36

18 64 Q. What I want to move to now, Mr. Haynes, is your  
19 involvement in the review that, Serious Adverse  
20 Incident review that was conducted in respect of the  
21 five patients who I indicated had not been triaged and  
22 who, upon review by the team of Consultants, it was  
23 recognised would have been red-flagged and ought now to  
24 be re-graded as Red Flag patients in 2017. There were  
25 five Incident Reports raised. Let me just take you to  
26 one by way of example. It's to be found at, I will  
27 just get this, I wanted to refer you to a Datix for one  
28 of these patients. Let me move straight to the SAI  
29 report. We will find that at AOB-02225. I'm going to

11:37

11:37

11:38

1 go through some aspects of that, Mr. Haynes. This was  
 2 a series of cases where the Incident Report was filed  
 3 in 2017 and the report issues on the 22nd May 2020;  
 4 isn't that correct?

5 A. I think that was when it was signed off at the Acute 11:39  
 6 Clinical Governance.

7 65 Q. Yes. The issue that arose that concerned each of these  
 8 five patients is that they hadn't been triaged on  
 9 various dates in 2015 and 2016. The facts that were  
 10 established indicated delays to diagnosis and treatment 11:40  
 11 ranging between six and ten months; isn't that right?

12 A. Yeah. These were five patients who were upgraded at  
 13 that Triage that myself and my colleagues did in early  
 14 2017 of the un-triaged referrals. They met Red Flag  
 15 criteria and were upgraded. These weren't the only 11:40  
 16 five that were upgraded. I think there was 24 that  
 17 were upgraded. Again, just consistent with some things  
 18 I said yesterday about our use of the SAI process,  
 19 these were patients who reviewed as -- these had cancer  
 20 so they had come to harm, but the other 19 who hadn't 11:40  
 21 been triaged didn't have an SAI done but they all were  
 22 at potential risk of harm because, equally, they could  
 23 have had cancer.

24 66 Q. Mm-hmm. Again, applying the criteria of yesterday,  
 25 they could equally have justified SAIs? 11:41

26 A. Yeah.

27 67 Q. I am sorry to jump around a little bit. Let me take  
 28 you to one example of what was said in the Datix. If  
 29 we go back to TRU-162114. This is a Datix raised

1 towards the end of 2017 by Mr. Young. It concerns one  
 2 of the five patients, that is Patient 15. It shows  
 3 here he was referred to the Urology Outpatients 28th  
 4 July '16 for assessment and advice on an episode of  
 5 haematuria, referral was marked Routine by the General 11:42  
 6 Practitioner. The referral was not triaged on receipt.  
 7 As a result of a Lookback exercise that Mr. Haynes has  
 8 just referred to, the referral was upgraded to Red Flag  
 9 and was seen in clinic in day 179, and on day 187 there  
 10 was a decision to treat, and on day 217 the patient had 11:42  
 11 a confirmed diagnosis of cancer. There has been  
 12 a resultant six month delay in Outpatient review and  
 13 recommendation for treatment for a bladder cancer as  
 14 a result.

15  
 16 In broad terms, because we don't have the time,  
 17 naturally enough, to devote to a full consideration of  
 18 this SAI review, but the SAI Review Team examined what  
 19 issues, Mr. Haynes, if you can remember?

20 A. From memory, the SAI team examined the issue of Triage, 11:43  
 21 so Triage being done or not done, and the impact of  
 22 that on the patient; the delay in terms of treatment,  
 23 and considered the harm as well, so what the outcome of  
 24 that was. They also examined the referral process as  
 25 well in the patient being referred, and a patient such 11:43  
 26 as this being referred with very clear suspected cancer  
 27 symptoms but on a routine pathway. Indeed, I think  
 28 from my memory, this patient had additional risk  
 29 factors for why he may be likely to have a bladder

1 cancer in the presence of blood in their urine.

2 68 Q. Yes. If we could bring up the report again, I want to  
3 take you straight to the recommendations that emerged.  
4 So that's AOB-02225. If we scroll through that to the  
5 recommendations section at AOB-02227. The 11:44  
6 recommendations that were issued were targeted at  
7 a number of constituencies. The first concern was  
8 directed to the HSCB in relation to the process of  
9 referrals, and that was the electronic process. You  
10 were recommending to the HSCB that, in their engagement 11:45  
11 with the General Practitioner Service, improvements  
12 would be made in terms of how referrals were directed  
13 to the Secondary Care Sector?

14 A. Yeah. Again, using the example of this patient with  
15 blood in their urine, suspected cancer referral 11:45  
16 criteria are relatively straightforward. If you have  
17 visible blood in your urine and you are over the age of  
18 45 you meet Red Flag or suspected cancer referral  
19 criteria. My recollection is that what we were  
20 suggesting is there needs to be a more, if you like, 11:46  
21 fail-safe way of flagging that patient as a suspected  
22 cancer referral that doesn't rely on the GP recognising  
23 that, and doesn't rely on a triaging doctor recognising  
24 it, because the patient's age and their symptom can be  
25 selected and automatically becomes a Red Flag referral. 11:46

26 69 Q. Could I scroll down the page then to the next set of  
27 recommendations. There's a recommendation there for  
28 GPs in terms of compliance with the NICE standard. In  
29 terms of the Trust, you were particularly focused --

1 just scroll up, please, so I can see all of the Trust.  
2 From recommendation 5, bring that up, please.  
3

4 One of the issues that you raised was that the Trust  
5 should examine whether the process of Triage was one 11:47  
6 that was capable of being performed as part of the  
7 Urologist of the week set of duties. Why was that of  
8 concern to the Review Team?

9 A. My recollection is that Mr. O'Brien, in his input into  
10 the SAIs, had raised that as one of his concerns. 11:47  
11 Again, my recollection is it was noted that while  
12 Mr. O'Brien had raised that as a concern, the other  
13 Consultants, who also conducted Urologist of the week  
14 activity and also had Triage, didn't have the same  
15 issue with not doing triage. I would add that that 11:48  
16 same model of the on-call, the Urologist of the week or  
17 the surgeon of the week, or the ENT surgeon of the week  
18 doing Triage, exists in many other services in other  
19 Trusts as well as within Southern Trust.

20 70 Q. Yes. I will come to Mr. O'Brien's observations in 11:48  
21 a moment. The process, just so that I understand it,  
22 was that he would get a draft copy of this report for  
23 his comment and observation, and then it would be  
24 signed off as final; is that right?

25 A. Yeah. 11:48

26 71 Q. Okay. Recommendation 7 seems apposite:

27  
28 "The Trust will develop a written policy for the  
29 guidance for clinicians in terms of the requirements of

1 the Triage process".

2  
3 was that a response to the Review Panel's understanding  
4 of how Mr. O'Brien triaged?

5 A. I think it was a response to, or a recognition in the 11:49  
6 failings of our system. If we want to monitor how  
7 individuals are performing in doing a task, we need to  
8 have clarity as to what we are monitoring them against,  
9 so what the expectation is in terms of timescale --

10 72 Q. Yes. 11:49

11 A. -- and in terms of output. By output, I mean the  
12 outcome of triage. Are we expecting an advance triage  
13 or are we expecting a check the category of referral is  
14 appropriate?

15 73 Q. Yes. If you have a Clinician who is doing Triage of 11:50  
16 a patient in five minutes and is doing certain tasks,  
17 and another clinician thinks an additional range of  
18 tasks is appropriate during the Triage process and it's  
19 taking him longer, the Clinicians need to understand  
20 what is expected of them when performing that task? 11:50  
21 what the employer expects of them?

22 A. Yes, what the minimum expected is in terms of the  
23 outcome applied. What you have done with the Triage  
24 and the timescale applied and then individuals can, if  
25 they elect to do more, they can do more, but they still 11:50  
26 have an understanding of what the expectation is.

27 74 Q. Yes. We will come to some of the recommendations that  
28 you direct to Mr. O'Brien, as I understand it, in  
29 a moment, with that thought in mind. Just scrolling --

1 maybe I should be saying up as opposed to down.

2  
3 Recommendation 8 is in respect of the default process,  
4 and the Review Panel is strongly saying this should be  
5 abandoned. By this stage, the signing off of this 11:51  
6 report, May 2020, it had not yet been abandoned?

7 A. I don't recall. I don't know.

8 75 Q. Has it been abandoned now?

9 A. I can't say for certainty. I would think so, but  
10 I haven't checked that. 11:51

11 76 Q. Then you make a recommendation for Audit of Clinician  
12 Compliance with the Triage arrangements and invited  
13 recommendation 10, what's described here as:

14  
15 "A robust system within which medical management 11:52  
16 hierarchy can deal with 'difficult colleagues' and  
17 'difficult issues', ensuring Patient Safety problems  
18 uncovered anywhere in the organisation can make their  
19 way upwards to the Medical Directors and Chief  
20 Executives' tables. This needs to be open and 11:52  
21 transparent with Patient Safety issues taking  
22 precedence seniority reputation and influence".

23  
24 what was that about? what was that intended to convey?

25 A. My primary part in that SAI panel was to provide 11:52  
26 urological expertise. within that role, we had made  
27 attempts to get someone from outside of the Trust,  
28 given my linkage both to the patients and my previous  
29 concern, so I did personally, in terms of expressing

1 opinion, try and narrow myself to the Urological,  
 2 direct Urological aspects. My memory of the  
 3 discussions is this was addressing the fact that, as we  
 4 have outlined here, this wasn't the first episode of  
 5 non-Triage for Mr. O'Brien; this had been a recurring 11:53  
 6 issue that just hadn't been successfully tackled.  
 7 Within the recommendations there's recommendations in  
 8 terms of expectations and then a monitoring process,  
 9 and with that monitoring process there needs to be  
 10 a clear understanding of how that then is escalated and 11:53  
 11 addressed when failure to comply with that happens, and  
 12 then how that is escalated if an attempt is made to  
 13 address step one of that process and that fails, there  
 14 needs to be clarity as to how that moves on to step 2  
 15 and step 3, and where communication within the Trust 11:54  
 16 hierarchy occurs with that.

17 77 Q. This was an independent-led SAI?

18 A. Yeah.

19 78 Q. You were providing your Urological output. Can  
 20 I suggest you were the person with greatest knowledge 11:54  
 21 of Mr. O'Brien and his practices. To the extent that  
 22 that recommendation is directed at a difficult  
 23 colleague, it would seem to suggest, your voice was  
 24 somewhere in the mix there. Is this an outworking of  
 25 it's difficult to challenge or it's a challenge to 11:54  
 26 challenge Mr. O'Brien?

27 A. I think it's an outworking of that same conclusion,  
 28 that same perception, but not just from my view but  
 29 from the knowledge that the same behaviours had

attempted to be challenged before by others, and failed.

79 Q. If we scroll down then to Consultant 1, who was Mr. O'Brien, isn't that right?

Recommendation 11 indicates that it's the view of the Panel that he:

"... needs to review his chosen 'advanced' method and degree of Triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner."

In one of your earlier recommendations directed to the Trust you were reflecting the view that there needs to be clarity by way of a policy in terms of how Triage should be done so that Clinicians are capable of understanding the expectations placed with them. How does that sit, that absence of clarity, with what you are saying to Mr. O'Brien essentially through this recommendation, that you shouldn't do it this way?

A. I think that recommendation is saying you need to look at the amount of time that you are deciding to take doing a process, that it's evident that your colleagues don't devote that same amount of time and, in doing so, they are able to do the Triage. The other thing, as in terms of what that process --

80 Q. Sorry, just before you move on. So you can do the triage. What the Review Panel seems to have arrived

1 at, in the way you have phrased that, is that there's  
2 an importance to actually doing some form of Triage in  
3 order to get it done, to get some movement, as opposed  
4 to what was understood to be Mr. O'Brien's way of doing  
5 it?

11:57

- 6 A. Yeah. At a very minimum, Triage is checking that the  
7 referral urgency, so Suspected Cancer or Red Flag,  
8 Routine or Urgent, is appropriate, and the largest  
9 amount of checking there is making sure that the  
10 condition described doesn't meet a suspected cancer  
11 referral criterion, so to upgrade patients. That's at  
12 its very minimum. As you move through Triage, you can  
13 do a more advanced Triage, as I would have done  
14 certainly through this time where, if patients are  
15 referred with certain symptoms that will always require  
16 certain investigations, they can be arranged at that  
17 time of Triage. The process I adopted for that was  
18 a series of standardised letters, so I didn't spend  
19 a significant amount of time in dictating a letter for  
20 every individual patient. They were sent standardised  
21 letters outlining what they had been referred for and  
22 what investigation they were going to get, and  
23 requesting a scan. That process took longer than that  
24 basic, that very minimum, but it didn't take as long as  
25 what Mr. O'Brien described where he telephoned every  
26 patient and effectively did a telephone consultation.  
27 So Mr. O'Brien's complaint to the time that Triage took  
28 was a direct result of his choice to telephone  
29 a significant number of patients and, in doing that, he

11:57

11:58

11:58

11:58

1 was not able to meet the bare minimum Triage for some  
2 patients, as identified in the patients who hadn't been  
3 triaged.

4 81 Q. You go on at recommendation 12 to say:

5  
6 "Consultant 1 needs to fashion his Triage in a way that  
7 meets the expected time limits".

8 Presumably those time limits set out within the EAP set  
9 of standards.

10  
11 That report, before it was signed off, would have been,  
12 as I said earlier, received in draft form by  
13 Mr. O'Brien. Let me just touch on some of the things  
14 he said, because it would appear that his concerns  
15 about what was contained within the draft report  
16 weren't accepted by the Review Team, or at least some  
17 of them weren't.

18  
19 Let me turn to what Mr. O'Brien has said. If we go to  
20 AOB-02284. In the second paragraph he says he believes  
21 the singular and significant flaw of the review has  
22 been to investigate the failure to Triage Urgent and  
23 Routine referrals in isolation of other pressures and  
24 Clinical priorities which he believes are evidently  
25 more important. He says that he believes these are  
26 greater Clinical priorities that cannot be compromised  
27 for the sake of Triage as they have been and continue  
28 to be.

1 It's back to the point I raised yesterday and drew  
 2 attention to this morning again, which is,  
 3 Mr. O'Brien's perspective is very much that, given the  
 4 frailties of the system that he has to work in, and you  
 5 have to work in for that matter, Triage cannot be given 12:01  
 6 the importance or the priority for all referrals sent  
 7 to him that the Trust would like, and that there's  
 8 a failure to recognise that in the Review Team's  
 9 findings?

10 A. I think the Review Team recognise that the pressures of 12:02  
 11 the service were not unique to Mr. O'Brien, yet the  
 12 failure to Triage was.

13 82 Q. If you scroll to the fourth paragraph down, he goes on  
 14 to say, dealing with your recommendation 6, that you  
 15 should review the wording so that the Trust would 12:02  
 16 re-examine or reassure itself that it is feasible for  
 17 the Consultant of the week to both perform the duties  
 18 associated with non-red flag referrals and the duties  
 19 of Consultant of the week. He goes on to say that:

20  
 21 "I believe it is crucially important that the duties 12:03  
 22 and priorities of the Consultant of the Week and the  
 23 expectations of the Trust in the conduct of those  
 24 duties and priorities be clearly agreed and expressed  
 25 in a written Memorandum of Understanding or similar." 12:03  
 26

27 To that point, that had not been achieved?

28 A. We would have certainly discussed the format of the  
 29 urologist of the week activities, and the way we worked

1 during that on a number of occasions during the  
 2 development of the presentation to the Director of  
 3 Commissioning in late 2014, and on a number of  
 4 occasions at Departmental meetings and general  
 5 discussions between each of us.

12:04

6 83 Q. Is it fair to say that across the Urology team, there  
 7 were a range of different views about the purpose and,  
 8 perhaps, the efficacy of dealing with Triage as part of  
 9 these duties and, in fact, in your observations to  
 10 Dr. Chada's investigation, I think you described  
 11 Triage, did you use the word pointless that context?

12:04

12 A. I think it's nonsense, actually.

13 84 Q. Nonsense. What did that reflect from your perspective?

14 A. I think within the text, Dr. Johnston has reflected  
 15 this thought process. In a process like referral in to  
 16 Secondary Care, any process works best if the first  
 17 decision is likely to be right almost all the time.  
 18 The best process would be a process, as I mentioned  
 19 earlier as an example, if you are over the page of 45  
 20 and you've got blood that you can see in the urine,  
 21 there shouldn't be any mechanism by which you can be  
 22 referred on anything other than a Red Flag basis.

12:05

23 Using technology available to us and electronic  
 24 referral forms, then the ideal situation would be that  
 25 that actually the referral category is right and  
 26 I don't need to double-check it. What Triage is doing,  
 27 or one of the things Triage is doing is it's utilising  
 28 Clinical time in a Service that hasn't got enough  
 29 Clinical time to check that the referral category is

12:05

12:05

1 right, rather than using technology and mandated fields  
2 to make sure that it's right at the outset. That is  
3 where I say I think Triage is nonsense. If we are  
4 having to check and you are getting a significant  
5 percentage are referred at the wrong category, and that 12:06  
6 carries a patient risk at the back of it, then surely  
7 a better process is one that ensures that it isn't  
8 wrong. At various points we would have discussed if  
9 any changes could be made to the electronic referral  
10 system. We would have used analogies of booking 12:06  
11 flights. If you were booking a holiday and there was  
12 a 5% chance that you booked a flight to the wrong  
13 destination it wouldn't be a very effective booking  
14 system. The same principle can be applied to  
15 referrals. 12:07

16 85 Q. Yes. You, in some sense, shared Mr. O'Brien's  
17 frustrations in respect of the process of triaging that  
18 confronted you as a busy Clinician. Where you parted  
19 with him was that you felt able to comply with the  
20 rules as regards Routine and Urgent referrals, whereas 12:07  
21 he couldn't find the time to do it as part of his  
22 duties as Urologist of the week?

23 A. Yeah. While I had a view personally about whether  
24 alternative systems could be adopted that made the  
25 requirement for this less of an issue, I didn't abandon 12:07  
26 it as a duty to carry it out, and I carried it out.  
27 I also, as I described, adopted strategies to  
28 streamline patients' contact with the Department by  
29 a form of Advance Triage that was as efficient in use

1 of my time as I could make it.

2 86 Q. If we scroll just to the bottom of the document,  
3 conclusions. Let me just see. Keep going, please.  
4 Sorry, I don't have a page number for this. Keep  
5 going, please.

12:09

6  
7 In what is a wide-ranging response to the draft SAI  
8 review, Mr. O'Brien reaches the following conclusions.  
9 He says that he does agree with the recommendations  
10 contained in the report with a number of caveats. He  
11 says he does believe that it is crucially important  
12 that recommendation be amended to ensure that the Trust  
13 developer a clear, agreed written policy of its  
14 expectations -- something you deal with in part of your  
15 review. He goes on to say in the next paragraph:

12:09

16  
17 "I believe that no Consultant Urologist should be  
18 expected to concern him or herself with reviewing their  
19 conduct of Triage to align themselves with his or her  
20 colleagues, especially when the colleagues claim to be  
21 conducting Triage in a similar manner. That proposal  
22 will be replaced, in my view, by a clear, agreed,  
23 written policy of what the Trust", to paraphrase,  
24 should expect.

12:10

25  
26 That seems to be a riposte to the recommendation  
27 contained in draft to him that he should seek to align  
28 himself to how his colleagues, you and perhaps others,  
29 were dealing with Triage. You presumably saw that

12:10

1 observation before signing off on the final report.

2 what do you make of that?

3 A. I mean, essentially you are presented with a Clinician  
4 who, the reason the SAIs had happened is because he had  
5 not been able to do the Triage of a significant number 12:11  
6 of referrals, and had not done it and had not alerted  
7 anyone that he hadn't done it. What he's saying there,  
8 in my interpretation, is, even though that's the case,  
9 I'm not willing to change the way I do it to try and  
10 meet the time scales the way that my colleagues do 12:11  
11 until someone tells me exactly what's expected of me.

12 87 Q. If we scroll down, finally, to -- just a little.

13  
14 This Review Report, as I have indicated earlier is  
15 delivered finally on 22nd May 2020, a period of some 12:12  
16 four or five years after the failures of Triage had  
17 occurred, and anything between two and a half and three  
18 years after some of the Datixes were raised. Within  
19 your statement to the Inquiry, you indicate that the  
20 Trust is aware of the risk of delay attendant in 12:12  
21 investigating some of these SAI cases. By any stretch  
22 of the imagination, this is a grossly delayed report.  
23 Would you agree?

24 A. As I have reflected in my statement, the process of an  
25 SAI report takes too long, and indeed this one took, as 12:13  
26 you highlight there, two and a half years. There are  
27 often multiple factors into why an SAI report can take  
28 so long. Some of them relate to challenges in  
29 bringing, often, panel members together for meetings

1 around the SAI, with panel members being busy  
2 clinicians who perhaps haven't got the availability to  
3 meet as urgently as would be ideal. Some of them  
4 relate to time taken to put together a report, or to  
5 draw together all the evidence. Within this SAI 12:13  
6 interviews were conducted with individuals, I seem to  
7 recall. I think Mr. O'Brien was at least had some feed  
8 in before his comments. There was other, if you like,  
9 things that needed arranging that were arranged around  
10 clinicians' schedules. Once a report starts to be 12:14  
11 drafted, that needs to be reviewed again by them same  
12 individuals who have busy schedules. For example,  
13 within this, I would have had to review the report and,  
14 unfortunately, these reports need time and  
15 consideration. They are not something you can review 12:14  
16 necessarily quickly, and sometimes that can take time.  
17 Opportunity for comment, as was provided to Mr. O'Brien  
18 in this report, was given, and that can take time.  
19 I think in this case, while initial suggested deadlines  
20 were given, that was pushed back and the comments came 12:14  
21 back later. The process takes time because of multiple  
22 factors that come together to get to the end,  
23 unfortunately.

24 88 Q. This report obviously is being signed off a month or so  
25 before Mr. O'Brien retires. Plainly, the utility of 12:15  
26 any of the recommendations, not just in this case but  
27 in any case where there is gross delay, is blunted the  
28 further you get in terms of time away from the adverse  
29 incident itself. If the adverse incident has happened

1 as a result of questionable practice four or five years  
 2 earlier, you would agree with me that there is some  
 3 importance to be attached to promptitude when trying to  
 4 identify the lessons that are there to be learnt from  
 5 the questionable practice?

12:16

6 A. Yeah. I mean, at the very least, the same practice  
 7 could be continuing.

8 89 Q. Sorry?

9 A. At the very least, you know, if you like, at the worst  
 10 end the same practice could be continuing while the  
 11 investigative process is ongoing, and recommendations  
 12 haven't been made.

12:16

13 90 Q. Yes. If the Inquiry was to think more generally about  
 14 your experience of the SAI process, dealing with this  
 15 particular set of circumstances -- we are going to go  
 16 on and look at some of the other patients in a moment.  
 17 What would you be suggesting to the Inquiry in terms of  
 18 the kinds of procedural improvements that could be made  
 19 to bring a quicker outcome?

12:16

20 A. Obviously a timescale related to the steps in an SAI  
 21 report are important, but I've mentioned that some of  
 22 the factors are actually the availability of the  
 23 clinicians. If clinicians either involved as, if you  
 24 like, the subjects of SAIs or the Panel members don't  
 25 have available time in order to conduct their duties,  
 26 then you inevitably end up in a position where there is  
 27 delay. You might want, and I'm sure we would all want,  
 28 at least a first meeting very quickly after the  
 29 establishment of an SAI, say, within a month, but

12:17

1 unfortunately, clinical activity would be booked and  
2 scheduled up to six weeks ahead of us, so immediately  
3 there's a challenge, if people haven't got time, that  
4 you can't have your first meeting for at least six  
5 weeks. That creates problems. It's availability and  
6 time within the Panel members' jobs. 12:18

7 91 Q. What's the solution?

8 A. I think the solution is either to take the approach of  
9 cancelling the clinical activity to facilitate and  
10 enable these to proceed at a quicker pace, or to have 12:18  
11 a designated group of Chairs, SAI Chairs who have fixed  
12 availability in their job plans prospectively to  
13 conduct that, then meetings and conduct the SAI  
14 investigations.

15 92 Q. One of the other observations contained in your witness 12:19  
16 statement in terms of some SAIs that you have  
17 presumably been a party to, is the sometime failure to  
18 tailor recommendations to the individual circumstances  
19 of the Clinician. In other words, if the Clinician is  
20 shown by the process to be weak or aberrant in 12:19  
21 particular aspects of his or her practice, the  
22 recommendations should seek to specifically grapple  
23 with that. Is that a weakness of the SAI process or  
24 some SAI reports that you have experienced?

25 A. Yeah, that's my view. Sometimes we can find that 12:19  
26 within the body of an SAI report it may identify an  
27 individual Clinician failing or issue, but that may not  
28 be subsequently picked up within the recommendations of  
29 the report as a specific recommendation related to that

1 individual or Clinician. These reports did have  
2 specific recommendations related to the Clinician.

3 93 Q. In other words, I'm sure you're too modest to say so,  
4 but this is the kinds of recommendations tailored to  
5 specific organisations and, ultimately, an individual 12:20  
6 Clinician, is that what you tend to hold up as if not  
7 a perfect example but something that gets closer to the  
8 concern that you were expressing?

9 A. I think if an identified causal factor in the incident  
10 that's being investigated is a behaviour or an action 12:20  
11 of an individual that is not a system-wide behaviour or  
12 action, then you need a recommendation that relates to  
13 that individual.

14 94 Q. Yes. Let me move on to another SAI dating from 2017  
15 that you were part of the Review Panel. It concerns 12:21  
16 Patient 16. This matter originated as a complaint from  
17 the daughter of Patient 16, a lady from whom the  
18 Inquiry heard in its June hearings. The concern that  
19 she was expressing, on behalf of her father, was the  
20 failure on the part of the Urology Service to arrange 12:22  
21 for the timely removal and replacement of a ureteric  
22 stent for her father, a cancer patient. The SAI report  
23 is to be found at PAT-000100.

24  
25 Again, Mr. Haynes, you are part of this panel. A green 12:22  
26 light to proceed with a SAI review was given in April  
27 2017. I'm not sure if it's clear on the face of that  
28 document, but this report signed off on 27th January  
29 2020, some nearly three years later, certainly more

1 than three years after the incident giving rise to the  
 2 concern. Again, is that to be taken as just one of  
 3 those things, a symptom of a process that didn't  
 4 arrange for the Clinicians participating in the process  
 5 to be able to devote sufficient time to getting it done 12:23  
 6 quicker?

7 A. As I say, it's multifactorial. That's one of the  
 8 factors. This SAI was also chaired by Dr. Johnston  
 9 externally. I think my memory is it was considered at  
 10 the same time as the five non-Triage SAIs, is my 12:23  
 11 memory.

12 95 Q. Yes. There were several issues in it, but the issue  
 13 which called attention to Mr. O'Brien's role was in  
 14 respect of communication coming into him and his  
 15 secretary seeking an appointment for admission of this 12:24  
 16 patient that was seemingly unanswered or not dealt  
 17 with. If I can just open the report at PAT-000112, and  
 18 if we just scroll down.

19  
 20 Mr. O'Brien in this context was labelled Consultant 12:24  
 21 Urologist 13. This is the issue that directly concerns  
 22 Mr. O'Brien and it says, second paragraph:

23  
 24 "There is no evidence of the letters sent to Consultant  
 25 Urologist 13" -- that's Mr. O'Brien -- "being 12:25  
 26 initialled to acknowledge receipt. The important 26th  
 27 November 2015 letter from Consultant oncologist 10 to  
 28 Mr. O'Brien initially requesting change of the stent  
 29 was stamped on the Craigavon Hospital chart 11th

1 December 2015 but there is no Consultant  
2 note/signature/handwriting evident on the letter to  
3 acknowledge receipt. This calls into question whether  
4 Mr. O'Brien was made aware, at that time, that the  
5 stent change was required. 12:26

6  
7 "However, there were several e-mail communications  
8 received shortly afterwards that should have brought  
9 this to his attention. This series of communication  
10 issues could be characterised as indicating a lack of 12:26  
11 acknowledging, reviewing and/or actioning  
12 correspondence."

13  
14 In its recommendations, the Review Team drew attention  
15 to this issue of clinicians dealing with 12:26  
16 correspondence. If we scroll down to page 115 of that  
17 series, that's PAT-000115.

18  
19 Mr. Haynes, help us if you can. Part of the concern of  
20 the Review Panel was that the Trust didn't have 12:27  
21 a system in place which allowed for the proper  
22 monitoring of, and actioning of correspondence by  
23 clinicians.

24 A. Yeah. Essentially, despite much of what we do being  
25 electronic, means of communication between Consultants 12:27  
26 within a hospital still tends to be, then and largely  
27 now, in the form of paper letters. If a patient is  
28 seen by the Oncology team in the Cancer Centre in  
29 Belfast and a letter is written to me in Craigavon,

1 that comes through the post to my secretary. Although  
 2 on receipt the secretaries would tend to stamp the  
 3 letter as to when received, there wasn't a process  
 4 whereby the system knew that that letter had been  
 5 received. The system knew when that letter had been 12:28  
 6 passed on to, in the example I gave, me, for me to read  
 7 it, and annotate what action, if any, is required from  
 8 that. That action may be simply to file it or that may  
 9 be to carry out something else. There was no  
 10 monitoring process for when that was returned from me 12:29  
 11 to my secretary for that, if you like, outcome to be  
 12 noted. That was, if you like, the problem that we had  
 13 recognised in the process of this SAI.

14 96 Q. The effect in this case of Mr. O'Brien not dealing with  
 15 his correspondence -- and I will come on to his 12:29  
 16 perspective in a moment. The effect of that was, from  
 17 the patient's perspective, profound, in the sense that  
 18 I think it was identified that there was a delay  
 19 between 26th November 2015 and 29th June 2016 before  
 20 the stent was removed and, I think replaced, and 12:30  
 21 a degree of pain and suffering associated with that  
 22 delay and a complicated or more complicated recovery  
 23 process of the stent and the replacement. I suppose  
 24 that puts into sharp focus the need for the Trust to  
 25 have a system of ensuring that clinicians are 12:30  
 26 responding to correspondence and, if not responding,  
 27 a provision or an arrangement for that to be spotted,  
 28 identified and addressed. Has that changed in the  
 29 interim?

- 1 A. I can certainly give example of how it functions in my  
 2 practice now. That is, upon receipt of a letter my  
 3 secretary will scan that electronically to a shared  
 4 folder on a shared drive so it's date-stamped as to  
 5 when that's received. I will manage that 12:31  
 6 electronically using software to annotate my comments,  
 7 dating my comments, and save it back to the same shared  
 8 folder, where my secretary is able to take it off and  
 9 she stores it herself on a hard drive, so there's  
 10 a clear record of when it's given to me, when I have 12:31  
 11 actioned and when it's taken off and actioned by my  
 12 secretary.
- 13 97 Q. Yes. In terms of the outsider, the Trust, a Trust  
 14 manager, how can they identify that you have perhaps  
 15 failed to do it for a month or two months or, in this 12:31  
 16 case, several months?
- 17 A. For me, that would be reliant on my secretary  
 18 highlighting that I haven't done it.
- 19 98 Q. Yes. The system beyond you and your secretary doesn't  
 20 know until, in this case, the patient's daughter 12:32  
 21 complains, or somebody else, perhaps another Clinician,  
 22 spots it?
- 23 A. Or my secretary escalates that I've not done it through  
 24 her line management.
- 25 99 Q. Sorry to cut across you. Is she given that, if you 12:32  
 26 like, supervisory responsibility vis-à-vis you? In  
 27 other words, if you are not doing your job, she has  
 28 liberty to raise that with her management?
- 29 A. My secretary is very aware that I am clearly of the

1 view that that is her role, and that's a protective  
2 role for me as well.

3 100 Q. Yes.

4 A. What I was just going to add is that I am aware, and  
5 it's currently a live thing, in that an alternative 12:33  
6 process for the inter Consultants, so inter Speciality  
7 referral process that will come through the electronic  
8 Triage system on ECR is developed and is due to be  
9 trialed in the near future. Indeed, one of the e-mails  
10 I have picked up this morning concerns that being 12:33  
11 trialed within Urology in Southern Trust in the near  
12 future.

13 101 Q. I said I was going to look at Mr. O'Brien's perspective  
14 on this. If we go to AOB-03494. Just the top of his  
15 letter, if we scroll up, please, to 03495. 12:34

16  
17 What Mr. O'Brien is saying here is that he is  
18 acknowledging receiving correspondence in respect of  
19 this patient, asking for admission to deal with the  
20 stent issue. He says: 12:35

21  
22 "The subsequent e-mails which I received from" -- his  
23 secretary or audio typist, and he gives the dates --  
24 "are typical of requests and enquiries which I have  
25 received every day for years from patients, relatives, 12:35  
26 GPs, MLAs, MPs and personnel in Trust management,  
27 regarding dates for admission. For years, I have had  
28 approximately 280 patients awaiting elective admission  
29 and re-admission. I currently have 228 patients

1       awaiting urgent elective admission dating back to  
2       August 2014, prior to Patient 16 having first been  
3       referred to our Department in March 2015."

4  
5       He goes on to say:

12:36

6  
7       "The failure to respond positively to any request for  
8       admission is a consequence of the lack of operating  
9       capacity provided by the Trust. The failure to respond  
10      in any way to every request is additionally  
11      a consequence of the lack of time provided and  
12      available to do so."

12:36

13  
14      There's two features there. He is saying, I don't have  
15      the time or didn't have the time, because of the  
16      frailties of the system within which I was expected to  
17      operate, to grant this patient a timely admission.  
18      Secondly, although I'm aware of getting these requests  
19      for assistance, I don't even have time to deal with the  
20      correspondence. Your observations on that?

12:36

21      A. I think it's notable the period of time. This was  
22      2015/16, and we've already discussed my concerns being  
23      raised through 2015 on two occasions, I think it was,  
24      about private patients being brought in very quickly  
25      after a consultation. Indeed, was it December 2016 my  
26      e-mail to Ronan Carroll about a routine TURP being  
27      brought in after a very short period of time?

12:37

28  
29      I think one reflection is that it appears that he can

1 respond to private patients' clinical urgency but not  
 2 a patient he has being contacted about who is also  
 3 urgent. I do recognise, and I have highlighted it  
 4 within my statement, the issue of us not being able to  
 5 meet demand, and I commented yesterday about the impact 12:38  
 6 on patients having delayed changes in dwelling stents  
 7 or delayed stone management with stents in situ, and  
 8 the potential risk of an increased or more complicated  
 9 procedure. There's almost a suggestion in his comment  
 10 that he'd just managed this change of stent on the same 12:38  
 11 urgency as everyone else on the urgent waiting list,  
 12 that's not entirely in keeping with how any Urologist  
 13 manage patients with stents in that require changes.  
 14 They are planned for changes. The manufacturers  
 15 recommend changes every six months. We endeavour to 12:39  
 16 meet that. On occasions, we are late, we are not able  
 17 to meet that, but that's not managing them in  
 18 a chronological manner with everyone else urgent back  
 19 to 2014. If that was the case, we'd have every patient  
 20 with a long term stent being admitted as an emergency 12:39  
 21 with a complication. While I recognise that he may not  
 22 have had the capacity to manage this patient as  
 23 urgently as he perhaps would have liked to, to say that  
 24 he couldn't manage him at all and, at the same time,  
 25 over that period of time, have patients that I have 12:39  
 26 identified who had short waits for less urgent  
 27 procedures arguably, who he happened to have seen  
 28 privately, just doesn't seem to fit together.  
 29 102 Q. If you don't have time within your waiting lists to

1 address this patient, and if you find that you don't  
2 have time to draft a letter, is there another approach  
3 that should be taken to alert the wider system to your  
4 lack of capacity in respect of a particular patient?

5 A. Again, and I would have done this myself on occasion 12:40  
6 where I've been in this almost exact situation of  
7 patients who have long term indwelling stents where  
8 I haven't got theatre availability, I will communicate  
9 with my colleagues and say this patient needs their  
10 stent changed and I haven't got any operating space, is 12:41  
11 there any chance someone can offer a date?

12 103 Q. Presumably, when you see correspondence not being  
13 answered for such a long period of time, that  
14 reinforces the point that the system needs to develop  
15 a way to identify that and challenge it? 12:41

16 A. Yeah. You know, we all get a significant volume of  
17 patient correspondence, we all get a significant volume  
18 of e-mail correspondence. As a system, we need to know  
19 where that correspondence relates to patients isn't  
20 being managed, isn't being actioned. As an individual, 12:41  
21 I think we also need to be alert and recognise that we  
22 need to ask for help and state very clearly not, I'm  
23 finding it difficult, but I'm not doing it, if you are  
24 not doing it.

25 104 Q. Yes. The Inquiry also has to look at these kinds of 12:42  
26 instances, both this patient, Patient 16 as well as the  
27 group of five patients we have just looked at in the  
28 triaging context, and Patient 10, the other Triage  
29 case, we have to look at these cases in a more rounded

1 way to see what those instances were telling or ought  
 2 to have been telling the Governance arrangements about  
 3 a practitioner employed doing very important work, had,  
 4 no doubt, a huge skill set but, for whatever reason,  
 5 judged by these examples, was struggling to deliver the 12:43  
 6 service which at least the Trust expected him to  
 7 deliver, and leaving aside the delay issue, because  
 8 some of these conclusions didn't emerge until 2020  
 9 itself, albeit before his retirement, but if you had  
 10 received the report, or had you produced the report as 12:43  
 11 part of a team with regards to the five non-Triage  
 12 cases or, to use this different example, Patient 16,  
 13 what would that have been saying or what that ought to  
 14 have been saying to the Trust about Mr. O'Brien and his  
 15 way of working? 12:44

16 A. I think what it said is that he's not on top of this  
 17 correspondence. There's factors that -- there's an  
 18 issue here akin to the issues that then became part of  
 19 the MHPS investigation. If you are, say, not acting on  
 20 a CT report, it's very similar to not acting on a piece 12:44  
 21 of paper, a correspondence letter. It's, I guess,  
 22 flagging that there is an issue in this individual's  
 23 way of work in his practice that is a risk.

24 105 Q. Let me turn to a couple of cases that deal with this  
 25 issue of this CT report. What I mean by that is that 12:45  
 26 we can see dotted across this narrative that on  
 27 a number of identified occasions, and of course there  
 28 could be other instances not identified, not least for  
 29 the Inquiry but also for the Trust, where, with regard

1 to patients for whom Mr. O'Brien has some element of  
2 management responsibility, there are investigations,  
3 they are sitting in report form to be accessed and they  
4 are not accessed on time or sometimes at all. Is that  
5 something that's familiar to you?

12:46

6 A. That's a factor in some of the patients within the  
7 subject matter, or the patients within the list here  
8 that we are considering. It's the same factor as I had  
9 highlighted in some of the concerns that I have raised.

10 106 Q. Yes.

12:46

11 A. Indeed, had been a factor in concerns raised prior to  
12 me starting in Southern Trust, as we heard last week.

13 107 Q. If we go to the case of Patient 92. You raised an  
14 Incident Report on 12th March 2019. If we just pull  
15 that Incident Report up. It's at TRU-162123. We can  
16 see, again just what I have said there, you are the  
17 reporter, it's being raised on 12th March 2019. Let me  
18 just read from the narrative. This was an inpatient  
19 admission between 29th November '17 and

12:47

20 7th December '17. There was to be a follow-up CT renal  
21 in three months. The CT was performed on 13th March  
22 2018 and reported on 20th March 2018, showing suspected  
23 renal cancer. There was a GP referral four months  
24 later on 17th July 2018. There had been no review and  
25 no follow-up after the CT scan. The patient, that is  
26 Patient 92, subsequently underwent surgical treatment  
27 of the renal cancer. To cut that down another way,  
28 this was one of Mr. O'Brien's patients. He had  
29 directed that a CT scan of the kidney would be

12:48

12:48

1 arranged. That was conducted in the Radiography  
2 Department and reported on promptly, and the scan  
3 report showing suspicion of renal cancer was there to  
4 be read but it wasn't read. No action was taken until  
5 a GP, fortuitously, wrote in, red-flagged the patient 12:49  
6 and the situation assumedly was recovered. Is that  
7 your understanding of what happened in summary?

8 A. Yes. The patient was in as an emergency with an upper  
9 urinary tract infection and a CT at the time had showed  
10 an abnormality which showed could be infection which 12:50  
11 related to inflammation or could be a cancer, and a CT  
12 scan was recommended. That was requested and performed  
13 in March, and reported as a renal cancer.

14 108 Q. The Serious Adverse Event report commented on the  
15 absence of a process to ensure the actioning of 12:50  
16 investigation results. If we could just open that  
17 report at TRU-41198? I think if we go to 90, please.  
18 Sorry. Go back to TRU-41198.

19  
20 The first recommendation, Mr. Haynes, is that: 12:52

21  
22 "The Trust is to review its current processes of  
23 communicating, recording and signing off suspected  
24 cancer diagnosis to patient's Consultants. The Trust  
25 is to consider a system in which results can be 12:52  
26 communicated to referring Clinicians and electronically  
27 signed off by the referring Consultant."

28  
29 Is that the kind of facility or system that, had it

1           been in place, might have addressed the issue in this  
2           case?

3           A.    That system is available for use. I can't recall when  
4           it became available, but I think at the time of this  
5           SEA it was available. It's certainly a system that 12:53  
6           I utilise myself and that is whereby, on the electronic  
7           care record, there's a tab for sign-off, on to which  
8           appears any report or result which has been requested  
9           by me when the report is made available. If  
10          a reporting Radiologist reports a CT scan now and 12:54  
11          that's confirmed, so signed off by him as complete, him  
12          or her, that, then, appears on my sign-off list on  
13          NIECR so I can assess it straight away. In my working  
14          practice, I work daily making sure I keep on top of  
15          them results coming in, and so if that result shows an 12:54  
16          abnormality, in this case I would have arranged for an  
17          Urgent Outpatient Review to see the patient, to inform  
18          them of the result and, subsequent to that, would have  
19          arranged staging an MDT discussion of treatment  
20          options. That system exists. I think the bigger thing 12:54  
21          is the engagement of clinicians in the systems that do  
22          exist. As a team --

23   109   Q.    Let me come to the DARO system in a moment.

24           A.    Yeah.

25   110   Q.    You made an observation at an earlier point about the 12:55  
26           absence of, in some SAI reviews that you are familiar  
27           with, the absence of directed Consultant specific  
28           recommendations. Here is perhaps an example of this.  
29           In this case, presumably it would have been helpful for

1 a recommendation to have been made for the attention of  
2 Mr. O'Brien to access, read and action investigation  
3 results that were ordered by him in respect of his  
4 patient?

5 A. And monitor that it's happening.

12:55

6 111 Q. Yes. This wasn't a new type of incident or a new type  
7 of shortcoming on the part of Mr. O'Brien, according to  
8 the Trust. In 2010, there was a case concerning  
9 Patient 95, clearly before your time, but I would just  
10 wish to have your observations on it. Patient 95 was  
11 the case of a swab retained in the cavity following  
12 surgery, and Mr. O'Brien was the surgeon.

12:56

13  
14 For the Inquiry's reference, there was an SAI report  
15 that dealt with the case and it failed to make any  
16 recommendation in association with the reading and  
17 actioning of CT reports.

12:57

18  
19 If we can open TRU-259876, and just so that I can see  
20 the bottom of it, please.

12:57

21  
22 This is an e-mail from 25th July 2011, the year after  
23 the SAI review had reported in Patient 95, Mrs. Trouton  
24 is writing to the Service and saying:

25  
26 "I know I have addressed this verbally with you a few  
27 months ago but just to be sure, can you please check  
28 with your consultants that investigations which are  
29 requested that the results are reviewed as soon as the

12:58

1 result is available and that one does not wait until  
2 the review appointment to look at them."

3  
4 Isn't that precisely the same concern that we've  
5 observed in Patient 92's case?

12:58

6 A. Yeah.

7 112 Q. A CT report available for the treating Consultant to  
8 review and action if necessary, but not being seen by  
9 that treating Clinician?

10 A. The safety net being the patient coming to clinic when 12:59  
11 they come to clinic in the context of a service with  
12 a significant capacity demand, mismatch and long waits  
13 for clinic, and therefore, in such a situation, that  
14 patient's scan may not be reviewed for a significant  
15 period of time. Indeed, it's echoed in later SAIs such 12:59  
16 as Patient 5 as an example I can just pull from the  
17 top.

18 113 Q. Yes. We will come to that in a moment. I just want to  
19 look at the remainder of that e-mail trail just before  
20 lunch. If we can go back, just scroll down. 12:59  
21 Mrs. Trouton has written, let me see the response to  
22 that. Go down to 75. And 74. Okay.

23  
24 Mr. O'Brien has evidently been informed of  
25 Mrs. Trouton's expectation in respect of the reading of 13:00  
26 results, and he writes in response to that and comments  
27 that -- I will read it all out:

28  
29 "I write in response to the e-mail informing us that

1 there is an expectation that investigative results and  
2 reports are to be reviewed as soon as they become  
3 available and that one does not wait until patients'  
4 review appointments. I presume that this relates to  
5 Outpatients, and arises as a consequence of patients  
6 not being reviewed when intended. I am concerned for  
7 several reasons".

13:01

8  
9 He sets out a series of questions, and in the middle  
10 of that, he asks:

13:01

11  
12 "How much time will the exercise of presentation take?  
13 Are there other resource implications to the  
14 presentation of results and reports for review?"

13:01

15  
16 A series of questions, and he says he believes that  
17 these need to be addressed.

18  
19 Just pausing there. I pointed out earlier  
20 Mr. O'Brien's perspective is within the system that he  
21 has to operate in, how can he possibly find the time to  
22 deal with that? The better approach from his  
23 perspective is to review the results at the time of the  
24 Clinic when the patient is coming in for review?

13:02

25 A. I think it's a complete abdication of responsibility  
26 for carrying out the action for patients under your  
27 care. It's interesting he asks whether he's to review  
28 all results and reports relating to patients under his  
29 or her care, irrespective of who requested them.

13:02

1 I would never ask that question as a Consultant,  
 2 whether it's a trainee, whether it's a non-Consultant  
 3 career grade, whether it's a Clinical Nurse Specialist  
 4 who requests an investigation on a patient under my  
 5 care; I'm the responsible Consultant. From memory, but 13:03  
 6 I believe the GMC duties of a doctor has comment on  
 7 responsibilities of Clinicians to look at results of  
 8 investigations of patients under their care.

9 Essentially and to say, I know -- I mean, knowing the  
 10 system we work in, I know I'm not going to be able to 13:03  
 11 see patients in the time that I should, but I'm not  
 12 willing to look at any results because the system  
 13 should enable me to see them and they don't in the time  
 14 that I have asked for, and if it can't it's everyone  
 15 else's fault and whatever falls out of that is nothing 13:03  
 16 to do with me; it's not a viewpoint that I could share  
 17 or ever understand.

18 114 Q. Yes. Let me just finally, before we break for lunch,  
 19 if we can go one page up again to TRU-259873. We have  
 20 on the 26th August 2011 an e-mail from Eamon to 13:04  
 21 Gillian. Eamon is Eamon Mackle, the Associate Medical  
 22 Director and he is writing to Gillian Rankin, who  
 23 I think, from memory, is the Medical Director at that  
 24 time? No?

25 A. I think Director of Acute Services. 13:04

26 115 Q. Director of Acute Services. Thank you. What  
 27 Mr. Mackle is saying:

28  
 29 "I have been forwarded this e-mail by Martina" --

1 Martina Corrigan, and that's Mr. O'Brien's -- "and  
2 I think it raises a governance issue as to what is to  
3 happen to the results of tests performed on Aidan's  
4 patients. It appears that at present he does not  
5 review the results until the patient appears back in  
6 Outpatients Department."

13:05

7  
8 We will have to speak to Mr. Mackle to see what was  
9 done with that Governance conundrum, but, judged by  
10 what you were seeing with Patient 92, you've referred  
11 as well to Patient 5, which was one of the 2020 SAIs.  
12 I don't know if you can remember the facts off the top  
13 of your head, but Patient 7 is -- others can correct me  
14 if they think I am wrong -- but appears to be another  
15 failure to action results and follow up. Albeit of  
16 a different kind of case, Patient 90, which was  
17 reported just before the Patient 92 case, Patient 90,  
18 you may recall, was a death following surgery. One of  
19 the observations of the SAI team in that case was that  
20 it was indicated in 2016, via a CT scan, that there was  
21 a requirement for an echocardiogram and that was not  
22 actioned, nor was there a formal preoperative  
23 assessment that might have spotted that issue prior to  
24 Mr. O'Brien taking the patient to theatre.

13:05

13:06

13:06

25  
26 After lunch, I will maybe return to some of the  
27 governance aspects that flow from that collection of  
28 similar cases, but I think now would be a suitable  
29 point. Ten minutes ago might have been a suitable

13:07

1 point!

2 CHAIR: Given what might have been suitable ten minutes  
3 ago we will not sit again until ten past two.

4  
5 THE INQUIRY ADJOURNED FOR LUNCH

13:07

6  
7 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

8  
9 CHAIR: Good afternoon, everyone. Mr. wolfe.

10 MR. WOLFE KC: Good afternoon. Chair, if you feel that 14:11

11 a break is required at any point, just let me know.

12 I don't intend to break but I realise that would be

13 selfish, perhaps. The likelihood is that what I'm

14 regarding as, sort of, scene-setting evidence, this

15 first phase of Mr. Haynes' evidence is unlikely to 14:11

16 conclude today, just looking at what I have to get

17 through. I suspect another half-day will be required,

18 probably the longer half of the day, the morning half

19 of the day as opposed to the evening half of the day.

20 I have mentioned that briefly in passing to Mr. Lunny 14:11

21 on the way in. I haven't had a chance to discuss

22 diaries with Mr. Haynes. I know that, as a surgeon, it

23 may not be possible to make the 13th, but that's what

24 our thinking is, and it can be discussed with his legal

25 team after today. 14:12

26 CHAIR: Yes. I mean obviously, Mr. Haynes, we are

27 aware of your commitments and if we can accommodate you

28 we will. Obviously we have a job to do too, so if we

29 can work together towards a mutually agreeable date,

that would be better.

MR. WOLFE KC: okay.

1           MR. HAYNES CONTINUED TO BE EXAMINED BY MR. WOLFE AS  
2           FOLLOWS:

3   116   Q.   Just before the break, we were looking at the issue of  
4           sign-off, that is the Clinician should be seeing the  
5           result of an investigation and looking at it and taking 14:12  
6           necessary action. We have looked at some cases where  
7           that hasn't happened with Mr. O'Brien. It did mention  
8           briefly, and I just want to look at the recommendation  
9           in the case of Patient 90. If we could bring up  
10          TRU-161146. 14:13

11  
12          The first recommendation is:

13  
14          "The Trust should develop and implement guidance for  
15          clinical rough sign-off with a monthly audit of sign 14:13  
16          off to be presented to the governance forums."

17  
18          I just want to check that I understand that. It's  
19          seeming to suggest that, at that time, there wouldn't  
20          have been guidance to Clinicians in respect of Clinical 14:13  
21          results sign-off, but going forward, the Review Team  
22          appear to want to see that, and they also want to have  
23          a process of audit in place so that the system knows  
24          where Clinicians are not looking at their results and  
25          not signing off and actioning. Is that a good layman's 14:14  
26          interpretation of what's going on there?

27          A.   Yeah. As I commented on a previous question in,  
28          I think, relation to the letters coming in, or it might  
29          have been Triage. If we want to monitor performance

1 against something we have got to have clarity as to  
 2 what the standard is we are monitoring against and how  
 3 that is then interpreted, audited or monitored, and  
 4 then how that is escalated when non-compliance occurs.

5 117 Q. Okay. Was it unclear to Clinicians that the early 14:14  
 6 reading of results and actioning, if necessary, in  
 7 light of those results, was that unknown to Clinicians?

8 A. I think it's apparent from my views that I've expressed  
 9 that an understanding that you have a responsibility is  
 10 certainly there with most of us without having to have 14:15  
 11 that what's expected written down, but it's also  
 12 apparent where you have issues arising out of not doing  
 13 that, that for others that understanding or  
 14 recognition, or acceptance of a responsibility for that  
 15 aspect of work doesn't appear to be within their work 14:15  
 16 and practice.

17 118 Q. Yes. It's obvious as this, isn't it: If you have gone  
 18 to the trouble to instigate a CT scan to rule in or  
 19 rule out a disease, particularly in the area of cancer  
 20 where you can have aggressive cancers progressing quite 14:16  
 21 quickly, it would be plain daft to leave those results  
 22 sitting in the ether for three, four, five months, or  
 23 whatever it might take, in a context where the waiting  
 24 list for reviews are, to put it mildly, less than  
 25 generous. Really, it's a matter of common sense for 14:16  
 26 a Clinician to look at them as soon as possible?

27 A. It certainly is for me. As I have said, my  
 28 understanding is that the GMC is clear that it's our  
 29 responsibility to action results of investigations we

1 request.

2 119 Q. We have seen in this brief potted history of the cases  
 3 that have come to this Inquiry's attention, 2010 with  
 4 the stent retention, 2018 in the case of Patient 90,  
 5 2018 again with Patient 92, and then the two cases in 14:17  
 6 2020. What does it say about the Trust's arrangements,  
 7 if this issue with this practitioner is known about in  
 8 2010 causes Mr. Mackle to say this is a Governance  
 9 issue, look at how Mr. O'Brien is protesting this with  
 10 a series of questions, and then the issue comes up 14:17  
 11 again and again, again and again, the system isn't  
 12 grappling with it, is it?

13 A. No.

14 120 Q. It's the same issue in different clinical or different  
 15 factual contexts all the way along this ten-year 14:18  
 16 period?

17 A. These are cases, as you've suggested under reporting  
 18 before, these are cases we know about where there has  
 19 been significant findings on the scans. Alongside  
 20 these will also be lots of patients who didn't get the 14:18  
 21 result of normal scans or scans without a significant  
 22 finding until their review appointment, which may have  
 23 been many months or even years later.

24 121 Q. In terms of the system, I'm a Clinician, I am routinely  
 25 not checking the results for my patients, has that been 14:18  
 26 grappled with today, November 2022? Is the system now  
 27 aware, via electronic process or audit, if this kind of  
 28 thing is happening in Craigavon today?

29 A. Within Urology, in my role as Divisional Medical

1 Director for Urology Improvement, we have a weekly  
 2 audit, exactly as described there, where we have  
 3 a report generated as to how many outstanding results  
 4 are awaiting sign-off by the Consultant Urologist.  
 5 I've developed that in a red, amber, green format so 14:19  
 6 results that are less than two weeks old, results that  
 7 are two to four weeks old, and results that are over  
 8 four weeks old. I know that within Urology, we have  
 9 a system working where all of the Consultants are  
 10 working utilising the electronic sign-off and the print 14:20  
 11 -- or the result yesterday, the result last week is the  
 12 only outstanding results are less than two weeks old,  
 13 so I know that, within Urology, we have developed that  
 14 system, and I've started speaking across the other  
 15 Divisional Medical Directors as to how that can be 14:20  
 16 translated across into other Specialties.

17 122 Q. Yes. I think the Inquiry might accept that sometimes  
 18 it's more difficult to develop a system-wide solution,  
 19 you know, that goes through, no doubt, numerous  
 20 committees and numerous obstacles before you get 14:20  
 21 a solution at the other end, but it's perhaps easier to  
 22 devise an individualised bespoke solution, so if you  
 23 know that a particular Clinician is falling foul of the  
 24 rule that you described earlier as sort of get to these  
 25 things promptly, then it should be a straightforward 14:21  
 26 matter of including that as part of a monitoring  
 27 arrangement?

28 A. Yeah. So if you are monitoring arrangements,  
 29 particularly if you are monitoring arrangement for the

1 example of results mandates an engagement with that  
2 electronic sign-off, getting reports on a weekly basis,  
3 which is exactly what I am getting, of an individual  
4 Clinician and essentially filtering that Excel file for  
5 signed off or not signed off, is a straightforward  
6 monitoring process. 14:22

7 123 Q. But it wasn't done?

8 A. That wasn't done.

9 124 Q. You speak in your statement about a system called DARO  
10 and I have stopped you several times from talking about 14:22  
11 it; now is your chance. Let me just orientate you.  
12 Your witness statement at WIT-53948, paragraph 69.9.  
13 I am going to bring you to Mr. O'Brien's e-mail  
14 presently, but just explain to us, if you can, DARO.

15 what, in the context of what we have been talking 14:23  
16 about, how does DARO assist or detract from this issue?

17 A. In terms of results, or any process in healthcare, we  
18 hear about Swiss cheese and essentially where problems  
19 happen, often patients have fallen through holes at  
20 multiple steps. In terms of monitoring or getting 14:23  
21 results, there is a potential that I may not get  
22 a result that was requested on a patient under my care  
23 on the electronic system. If, for instance, a junior  
24 doctor selects the incorrect Consultant, or there are  
25 two Mr. Haynes and they select the other Mr. Haynes 14:24  
26 then that result might come to another Consultant. If  
27 step 1 of my process for managing results fails, then  
28 I need a second step and a third step and, I have  
29 described the DARO process there as a safety net

1 process. The electronic system for me and my  
2 colleagues in Urology is our first step of that  
3 process. In addition to the electronic results, for  
4 Radiology, for instance, and for Pathology, the result  
5 is printed and sent to our secretaries as a paper 14:24  
6 result, and our secretaries are able to check whether  
7 we've actioned that against, has it been signed off on  
8 ECR. Then a third is what if that piece of paper  
9 doesn't reach our secretaries, goes missing, then  
10 that's where the DARO process comes in. If a patient 14:25  
11 has seen me in clinic and I have requested a CT scan,  
12 then my secretary will add that patient to the DARO  
13 list as awaiting a CT result. Each month, my secretary  
14 will check against that DARO list if them patients have  
15 had the CT done, has it been reported and has the 14:25  
16 report been actioned, and then take them off that.  
17 It's a safety net within that, if you like, I have just  
18 described a three-step or a three-point process.

19 125 Q. Yes. We can see, if we open an e-mail from  
20 a Mrs. McCall at WIT-55864. She is writing on 30th 14:25  
21 January 2019 to what I take to be to a number of  
22 members of staff, including a Noeleen Elliott who is  
23 Mr. O'Brien's secretary. Are these medical secretaries  
24 in the main?

25 A. Yes. 14:26

26 126 Q. Yes. She is writing in order to explain, so far as  
27 I can see, the DARO system and how it should be used.  
28 She's saying that:  
29

1 "If a Consultant states in the letter 'I am requesting  
2 CT," et cetera and will review with the result'. These  
3 patients all need to be DARO'd first, pending the  
4 result, not put on a waiting list for an appointment at  
5 this stage. There is no way of ensuring that the 14:27  
6 result is seen by the Consultant if we do not DARO.  
7 This is our fail-safe so patients are not missed. Not  
8 always does a hard copy of the result reach us from  
9 Radiology so we cannot rely on a paper copy of the  
10 result to come to us. 14:27

11  
12 Only once the Consultant has seen the result should the  
13 patient be then put on the waiting list for an  
14 appointment if required and at this stage the  
15 Consultant can decide if they are Red Flag appointment, 14:27  
16 Urgent Or Routine and they can be put on the waiting  
17 lists accordingly."

18  
19 So your description of a fail-safe mechanism, use DARO  
20 and you keep track of the CT result? 14:27

21 A. Yeah.

22 127 Q. Further up the page towards the top of WIT-55862 --  
23 sorry, at the bottom, at the bottom, Mr. O'Brien  
24 replying to Ms. McCall, and he says that he has been:

25  
26 "... greatly concerned, indeed alarmed, to have learned  
27 of this directive which has been shared with 'him' out  
28 of similar concern."  
29

1 He says that:

2  
3 "The purpose of, or the reason for, the decision to  
4 review a patient is indeed to review the patient.

14:28

5  
6 The patient may indeed have had an investigation  
7 requested, to be carried out in the interim, and to be  
8 available at the time of review of the patient.

9  
10 The investigation may be of varied significance but it 14:29  
11 is still the Clinician's decision to review the  
12 patient. One would almost think from the content of  
13 the process that Ms. McCall has sought to clarify, that  
14 normality of the investigation would negate the need to  
15 review the patient, or the Clinician's desire or need 14:29  
16 to do so.

17  
18 One could also conclude that if no investigation is  
19 requested, then perhaps only those patients are to be  
20 placed on a waiting list for the review as requested, 14:29  
21 or are those patients not to be reviewed at all?"

22  
23 So a series of rhetorical questions. Then he goes on  
24 to give an example down the page. He makes the point  
25 that secretarial staff are being consulted in relation 14:29  
26 to this as opposed to Consultants, who, he says, should  
27 be consulted. You then come in on this because  
28 presumably Mrs. McCall has directed your attention to  
29 the reply?

1           A.    I was copied in by Mr. O'Brien to the reply, I believe,  
2                    along with my colleagues.

3   128   Q.    Okay. If we go to WIT-55862. Are we on that page?  
4                    Mr. Haynes, your response is to push back against what  
5                    Mr. O'Brien is saying. First of all, how did you           14:30  
6                    interpret what he was saying? He was asking a lot of  
7                    questions. He was suggesting that it's really a matter  
8                    for the Consultant to decide when a review should be  
9                    listed or should be notified to the system, and that  
10                  the DARO process, as described by Mrs. McCall,           14:31  
11                  shouldn't interfere with the Consultants' autonomy on  
12                  these issues?

13          A.    If you look at the DARO process as described by  
14                  Ms. McCall and apply that to Patient 92, who we covered  
15                  before, who had that CT scan, that follow-up CT scan in   14:31  
16                  March, if she had been on the DARO list, at the end of  
17                  March that list would have been able to be checked.  
18                  The fact that she had had a CT scan showing a kidney  
19                  cancer would have been picked up and she could have  
20                  been offered a Red Flag appointment at that point, as   14:31  
21                  Ms. McCall has indicated in her e-mail. The plan that  
22                  was in place for that patient, where she wasn't on the  
23                  DARO list, meant that she sat in a review backlog  
24                  waiting to come to Clinic for the urgency of the report  
25                  to be noted. Mr. O'Brien's approach to it, to me, fits   14:32  
26                  again with my comment earlier of an abdication of  
27                  a responsibility to have a system, or engage in  
28                  a system to review results of patients -- of scans of  
29                  investigations that you have requested on patients.

- 1 129 Q. I take it that, to your knowledge, he didn't use DARO  
2 at all?
- 3 A. DARO is not utilised by the Consultant; it's our  
4 secretarial team use the DARO process. It happens for  
5 me and for most -- well, to my knowledge, all my 14:32  
6 colleagues, by our secretaries, with investigations  
7 that results are identified that we haven't found  
8 through our other processes being flagged up to us by  
9 our secretaries when they do that check of the DARO  
10 list. 14:33
- 11 130 Q. The fact that she, the secretary, in conjunction with  
12 Mr. O'Brien, wasn't using that fail-safe, was that  
13 known?
- 14 A. It is evident from that correspondence that Mr. O'Brien  
15 and his secretary didn't feel that they should apply 14:33  
16 the DARO process to the patients under the care of  
17 Mr. O'Brien.
- 18 131 Q. What's your understanding of the rationale for that?
- 19 A. I can only repeat the rationale he's put in his e-mail,  
20 that is he'd already decided that if the patient needed 14:33  
21 a review appointment, they should be waiting for  
22 a review appointment, they shouldn't be on another  
23 list. He seems to have not accepted that that review  
24 appointment might not be for many years, and that  
25 patient may sit for many years with an un-actioned 14:34  
26 potentially abnormal scan.
- 27 132 Q. This provides further evidence to you, as his Associate  
28 Medical Director, of a Clinician not willing to conduct  
29 his practice in accordance with the expectations of his

1 employer?

2 A. Yeah.

3 133 Q. The question is: And yet, it's not monitored, this  
4 aspect -- I know we will go on in a moment to look at  
5 some of the aspects of his practice that were  
6 monitored, but the actioning of results was not  
7 something that was monitored even though there were  
8 clear indicators that would give rise to a suspicion,  
9 perhaps a strong suspicion, that this was a part of  
10 practice that he didn't, for whatever reason, wish to  
11 engage in?

14:34

14:35

12 A. At this time, the MHPS report had come out, I think at  
13 the end of 2018, within the return to work there was  
14 a monitoring process, but I don't believe it covered  
15 this aspect of his work, no.

14:35

16 134 Q. No. I wonder would this kind of knowledge, this kind  
17 of world view of how I am to address the results of  
18 investigations, whether it fell to you, with his  
19 Clinical Director, to challenge that, given that it was  
20 known and subjected to monitoring for compliance?

14:36

21 A. As you say, I addressed it directly with him at that  
22 time in my reply, but I also escalated it to the  
23 Medical Director at the time in the subsequent  
24 forwarded e-mail, given that, at that time, as I say,  
25 the MHPS monitoring, that process was still ongoing and  
26 that process, in terms of the Oversight Group from  
27 that, didn't involve me. I escalated it to the team  
28 who were in the Oversight Team by escalating it to the  
29 Medical Director.

14:36

1 135 Q. To your best knowledge, again, nothing was done to  
2 monitor that aspect of his practice?  
3 A. To bring this into that process, not that I'm aware of.  
4 136 Q. Yes. Because, as you know, there were two further  
5 cases to be discovered in 2020? 14:37  
6 A. Yeah.  
7 137 Q. In terms of an abdication of responsibility, if you're  
8 passing it up the line to the Medical Director's Office  
9 because you aren't to get involved with monitoring  
10 issues, is that an abdication of responsibility on the 14:37  
11 part of the Medical Director's Office or those charged  
12 with monitoring him?  
13 A. Without knowing what was done with receipt of that,  
14 I don't know whether that was considered by the  
15 Oversight Team in terms of that MHPS outcome. 14:37  
16 138 Q. We know that two cases weren't caught in any form of  
17 net, and I'm just wondering whether you were aware of  
18 whether a net had been created for the purposes of  
19 catching?  
20 A. I wasn't aware of any additional monitoring being 14:38  
21 brought in with regards this. I'm sure we will get to  
22 the Backlog Report and concerns that I'd escalated with  
23 regards to the Backlog Report. On the face of it, that  
24 Backlog Report included a report of the numbers of  
25 results awaiting action for each Consultant, and so it 14:38  
26 was within that Backlog Report, it's possible that  
27 there was a belief that that Backlog Report was  
28 adequately monitoring this aspect of practice.  
29 139 Q. We will come on to look at what was being monitored

1 through that action plan in a moment. One other point  
 2 that you make, you make it specifically in relation to  
 3 Patient 92 and it's concerning -- I will not bring it  
 4 up on the screen unless you need it. You make the  
 5 point that one of the frailties of the SAI and the 14:39  
 6 consequential of the SAI process is that action plans  
 7 do not get implemented quickly enough, that there's  
 8 delay and I suppose you'd call in aid the delay in  
 9 Patient 92's action plan as being in some sense  
 10 critical in allowing other cases of a similar nature, 14:40  
 11 a similar shortcoming, to proceed undetected. Is that  
 12 a problem within the Southern Trust in particular, in  
 13 your experience, in terms of getting recommendations  
 14 moved into the action plan stage and then out into the  
 15 implementation stage? 14:40

16 A. I've made that comment without knowing that, in 2010,  
 17 with that retained swab, there was a similar issue  
 18 previously as well.

19 140 Q. Just to interject, the problem, in 2010, was they  
 20 didn't even make a recommendation in terms of that 14:40  
 21 practice. It was left locally to management to make  
 22 a comment about it. It was supposed to be a Governance  
 23 issue to be taken forward but --

24 A. Yeah. In Patient 92, there was a patient who had  
 25 a scan result that didn't get any action and had 14:41  
 26 a delay in her treatment potentially as a direct impact  
 27 of that. Actually, enacting or bringing about either  
 28 monitoring of an individual or, as you have mentioned,  
 29 a system-wide change in terms of how all clinicians

1 manage results and are monitored against results, has  
2 taken time and potentially, well specifically with  
3 Mr. O'Brien, time passed from that point, and other  
4 patients had the same issue happen.

5 141 Q. Yes. I spoke this morning about the delays. There's 14:41  
6 delays with action plans. There's delays in getting  
7 SAIs completed. I should have drawn to your attention  
8 an observation which Mr. O'Brien makes in his  
9 correspondence to your Review Team as part of the SAI  
10 in connection with Patient 16, I think. I will just 14:42  
11 check that.

12  
13 If we could have up on the screen, please, PAT-000122.  
14 This is 28th October 2019, an e-mail from Connie  
15 Connolly to Mr. O'Brien. You will remember that this 14:43  
16 SAI started life in 2017, and she's writing to  
17 Mr. O'Brien and saying to him:

18  
19 "I would be grateful if you could read over the  
20 reports". 14:44

21  
22 I suspect this is both the Patient 16 report and the  
23 five patients' report which are being considered at the  
24 same time, albeit separately.

25 14:44  
26 She is asking him to respond within two days on the  
27 back of an investigation that's taken three years to  
28 complete. What was driving this? Was Patient Safety  
29 driving this, or was there a sense of embarrassment

1           that we'd better get this report out quickly because  
2           I think Patient 16's daughter had gone to the Ombudsman  
3           in relation to her complaint? Mr. O'Brien has a point,  
4           first of all, doesn't he?

5           A.   That's a very short timescale that he's been given. 14:45  
6           I don't recall being involved in a discussion of what  
7           was a reasonable deadline to expect.

8   142   Q.   You would accept that if Patient Safety was being taken  
9           seriously, albeit that there may well be many  
10          mitigations for the delay, Patient Safety is rather 14:45  
11          lost in the discussion if it's taking three years to  
12          produce an outcome?

13          A.   As I've said and reflected in my statement, the time  
14          taken for the SAI process is too long.

15   143   Q.   Each of those incidents that we have looked at over the 14:46  
16          past two days has been reported, albeit in some cases,  
17          such as Patient 92, the SAI report isn't to emerge  
18          until after the MHPS investigation. They were all in  
19          the system, some have reported, not all have reported,  
20          MHPS is underway, and you have an opportunity to 14:46  
21          contribute to the MHPS process as a witness. I don't  
22          want to take you through all of your statement, but  
23          I just want to touch on some parts of it.

24  
25          You provide a witness statement to Dr. Chada's 14:46  
26          investigation in May of 2017. If we could just bring  
27          that up. It's at WIT-55704. Talk me through the  
28          process of this. Do you go and meet Dr. Chada and she  
29          asks you some questions and then this is written up as

1 a statement for you to sign?

2 A. I think that was the process, from memory, yes.

3 144 Q. Yes. I just want to step through it rather quickly.

4 You deal with many of the issues we have covered over

5 the past day or so in your evidence. At paragraph 8, 14:47

6 for example, I think that's a reference to the case of

7 Patient 10, which you discovered in January 2016. You

8 deal in some detail with the Triage issue. At

9 paragraph 17, you go on to deal with situations where  
10 notes are not available to you because, I think you are 14:48

11 suggesting, Mr. O'Brien has them at home or in his

12 office. So I think you refer to two patients, one of

13 whom might be Patient 103, I think, that we discussed

14 yesterday.

15 14:48

16 Scrolling down to paragraph 22, you are dealing with

17 the issue of dictation. That's from the South West

18 Area Hospital there appeared to be no dictation, no

19 outcome sheets and no notes brought back. You go on at

20 paragraph 23 to say: 14:49

21

22 "It appeared to me to be accepted practice that

23 a senior member of the team did not do dictated

24 outcomes from clinics."

25 14:49

26 That speaks to, I suppose, a wider knowledge within

27 Urology Services that this was something he didn't do.

28 It was well known?

29 A. That was my impression.

1 145 Q. Then you go on to say:

2

3

4

5

6

7

8

9

10 what did you mean by that?

14:50

11 A. So the Servicing for Fermanagh patients in the Team  
 12 South model was provided from the Team South which was  
 13 Southern Trust, and so for the clinics for patients in  
 14 South West Acute Hospital, which is part of the Western  
 15 Trust their notes were Southern Trust notes. The  
 16 mechanism developed for getting Southern Trust notes to  
 17 the clinics in South West Acute Hospital in Western  
 18 Trust was that they were transported there by the  
 19 Consultant, so they were in the car of the Consultant  
 20 and taken to Clinic, and then transported back by the  
 21 Consultant. Living, if you like, in between South West  
 22 Acute Hospital and Craigavon Area Hospital, it was only  
 23 natural that Mr. O'Brien would not drive past his house  
 24 at the end of a day to go to Craigavon to take the  
 25 notes back but would stop at home. It would be  
 26 appropriate for him to not leave them notes in his car  
 27 overnight and take them into the house because of the  
 28 attendant risks of them going missing from the car.  
 29 When I have said "we have created this issue", what I'm

14:50

14:50

14:51

14:51

1 referring to is we've created a system that relies on  
2 Mr. O'Brien and Mr. Young, who also did clinics in  
3 South West Acute Hospital, to transport notes to and  
4 from the hospital.

5 146 Q. Yes. Presumably it was also a feature of this that he 14:51  
6 needed to retain the notes if he hadn't dictated?

7 A. That's what I assume is why he didn't return them,  
8 because he had actions outstanding from the clinic that  
9 needed doing.

10 147 Q. Six months after making this statement, you assume the 14:52  
11 role of Associate Medical Director. Is it fair to say  
12 that, by this stage, given your knowledge of  
13 Mr. O'Brien as set out in this statement and your  
14 knowledge of these incidents, that you considered him  
15 to be a Patient Safety risk? 14:52

16 A. I had concerns, as I've documented in the concerns I've  
17 raised, about many aspects of his practice, which all  
18 translated into Patient Safety issues.

19 148 Q. Yes. Did you regard him as a Patient Safety risk?

20 A. I wouldn't have raised them concerns if I didn't, so, 14:53  
21 yes.

22 149 Q. There was in place an action plan with a monitoring  
23 component, which we will look at in a moment. By the  
24 time you became Associate Medical Director at the end  
25 of that year, you've told us that you weren't aware of 14:53  
26 that monitoring plan?

27 A. The monitoring plan which was developed when he  
28 returned to work in early -- in 2017, was developed,  
29 and I was unaware of that having been developed.

1 150 Q. Yes. You will recall our discussion of your job  
2 description yesterday, you had a responsibility for the  
3 safety and capability of your medical workforce, that  
4 was your contractual responsibility to the Trust. They  
5 had given you this job description to comply with and 14:54  
6 you had to provide assurances back into the Medical  
7 Director's Office in respect of the matters contained  
8 within that job description, including the safety of  
9 medical practice. You are deprived of the information  
10 in respect of a monitoring plan. You don't even know 14:54  
11 it exists?

12 A. No.

13 151 Q. You, nevertheless, have a concern that Mr. O'Brien is  
14 a Patient Safety risk. How can you conduct your  
15 medical safety role as AMD if you have that opinion of 14:55  
16 him and, for all you know, there's nothing in place to  
17 monitor his continued performance?

18 A. While I was not aware of the monitoring, I was aware  
19 that a MHPS process was underway. I was aware that  
20 that process had been taken on with the Medical 14:55  
21 Director and there was other clinical managers involved  
22 in that. Rather than me not being aware of there being  
23 anything, I was aware that there was a process that  
24 was, to my mind, managing the concerns that had been  
25 raised, or should have been managing the concerns that 14:56  
26 I'd raised about Mr. O'Brien. So, if you like, within  
27 the Surgery and Elective Care Clinical team,  
28 Mr. O'Brien was separate and, to me, to my mind being  
29 managed through that process regarding the concerns

1 I had with regards Patient Safety and not being managed  
2 directly by me through that.

3 152 Q. I know, and we will come to look at it presently, that  
4 at some point, and you can maybe help us specifically  
5 with regards to when that point arises, but at some 14:56  
6 point you do become aware of the action plan and the  
7 monitoring component. Can you think of any good reason  
8 why you wouldn't have been notified of that monitoring  
9 plan or monitoring arrangement as soon as you became  
10 AMD, even if you're not to be involved with the 14:57  
11 monitoring? Surely you need the assurance, the  
12 specific assurance of knowing what's going on with  
13 regard to a clinician who, to your mind, is a Patient  
14 Safety risk?

15 A. I think it would have been best if I had been aware as 14:57  
16 soon as I became AMD as to what and how the monitoring  
17 was undertaken, as it would have potentially led to me  
18 raising my concerns about the synthesis of the data  
19 that was being used to monitor his performance against  
20 the requirements of that return to work monitoring 14:57  
21 process.

22 153 Q. We will go on to look at, you did have concerns about  
23 the reliability of the data. I have some other  
24 questions to direct to you about the adequacy of the  
25 plan itself. Before we reach that stage, the MHPS 14:58  
26 report emerged and reached Dr. Khan's office in the  
27 middle of June 2018. After some consideration, he  
28 produced a determination in October 2018. Let's just  
29 look at the findings that Dr. Khan reached. If we can

1 pull up WIT-55697. Here we have his determination.  
2 Have you ever been given a copy of this?

3 A. I have, yeah.

4 154 Q. At what point were you given a copy?  
5 A. I don't specifically recall. 14:59

6 155 Q. But it was in the context of your role as AMD?  
7 A. It was at a later point, is my memory, than when it  
8 came out.

9 156 Q. Just as we step through this, you can see his various  
10 observations. There are clear issues of concern about 15:00  
11 Mr. O'Brien's way of working, his administrative  
12 processes and his management of his workload. The  
13 resulting impact has been potential harm to a large  
14 number of patients, numbered at 783, and actual harm to  
15 at least 5 patients. 15:00

16  
17 Just scroll down. It says:  
18  
19 "As a senior member of staff Mr O'Brien had a clear  
20 obligation to ensure managers within the Trust were 15:00  
21 fully and explicitly aware that he was not undertaking  
22 routine and urgent triage..."

23  
24 Then he sets out various recommendations that he feels  
25 ought to be taken forward. 15:01  
26

27 If we look at WIT-55701. I want to start, Mr. Haynes,  
28 there's a recommendation within this report from  
29 Dr. Khan that the investigation has highlighted issues

1 regarding systemic failures by managers at all levels,  
2 both clinical and operational within the Acute Services  
3 Directorate. The report identifies that there were  
4 missed opportunities by managers to fully and address  
5 the deficiencies in practice of Mr. O'Brien. No-one 15:02  
6 assessed the extent of the issues or properly  
7 identified the potential risks to patients.

8  
9 It goes on at the bottom paragraph:

10 15:03  
11 "In order for the Trust to understand fully the  
12 failings in this case, I recommend the Trust to carry  
13 out an independent review of the relevant  
14 administrative processes with clarity on roles and  
15 responsibilities at all levels within the Acute 15:03  
16 Directorate and appropriate escalation processes."

17  
18 When you did see the report, I assume you observed that  
19 recommendation. What it speaks to is a failure on the  
20 part of management, at various levels, to effectively 15:03  
21 engage with the information that was in front of them  
22 with regard to Mr. O'Brien's shortcomings and,  
23 assumedly, to a failure to provide him with the support  
24 necessary to change or, alternatively, to take steps if  
25 he wasn't prepared to change. Did that stand out to 15:04  
26 you when you read it?

27 A. It stood out to me as reinforcing an impression that  
28 I'd commented on, if you like, in my statement to the  
29 MHPS investigation, commenting that much of this,

1 I think, was recognised as his way or accepted  
2 practice.

3 157 Q. That failing, if you like, on the part of management,  
4 was familiar to you? Take an example, we looked at it  
5 this morning, you raised the issue of private patients 15:05  
6 on at least three occasions, at least three occasions  
7 that we saw in writing, but it was your sense that  
8 nothing was being done?

9 A. It's my sense that that got tackled as a result of the  
10 MHPS investigation, or at least the initial return to 15:05  
11 work monitoring plan, which, to my knowledge, beyond  
12 that point it didn't happen again. But it took until  
13 then for it to be tackled.

14 158 Q. We have also observed the multiple examples of the  
15 system being aware that Mr. O'Brien wasn't actioning 15:05  
16 the results of investigations, the CT reports, but,  
17 again, management, albeit having that knowledge, would  
18 not have appeared to have engaged with the issue.

19  
20 In terms of that recommendation, we know, the Inquiry 15:06  
21 knows that it wasn't taken forward until the middle of  
22 2020. Did you make any suggestion or issue any  
23 direction, to the best of your recollection, in  
24 relation to that aspect of Dr. Khan's findings?

25 A. As I say, it was at a much later date that I became 15:06  
26 aware of the report and the recommendations within the  
27 report. I can't specifically remember the dates, but  
28 my understanding of that report in having not received  
29 it initially, would have been that that was being taken

1 forwards elsewhere. So while I may have recognised it,  
 2 I may not have, and I evidently didn't, chase up to ask  
 3 has that been done?

4 159 Q. Because if there's no managerial bulwark to address  
 5 shortcomings or if it has inadequacies that haven't 15:07  
 6 been addressed, then there's a risk, at the very least,  
 7 that the shortcomings of the past will simply be  
 8 replicated?

9 A. Mm-hmm.

10 160 Q. The part of the report that was directly concern you 15:07  
 11 or, if implemented, might have directly concerned you,  
 12 is at WIT-55699. Just at the top of the page Dr. Khan  
 13 sets out his view:  
 14

15 "That in order to ensure the Trust continues to have an 15:08  
 16 assurance about Mr O'Brien's administrative practices  
 17 and management of his workload an action plan should be  
 18 put in place with the input of PPA or NCAS, the Trust  
 19 and Mr. O'Brien for a period of time agreed by the  
 20 parties". 15:08

21

22 "The action plan should be reviewed and monitored by  
 23 Mr. O'Brien's Clinical Director and Operational  
 24 Assistant Director within Acute Services, with  
 25 escalation to the AMD and Operational Director should 15:09  
 26 any concerns arise. The CD and Operational AD must  
 27 provide the Trust with the necessary assurances about  
 28 Mr. O'Brien's practice on a regular basis. The action  
 29 plan must address any issues with regards to patient

related administrative duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time."

There's a number of aspects to that, but it is the case, is it not, that none of that was taken forward?

15:09

A. My understanding is that after the issuance of that report, Mr. O'Brien raised a grievance with the process and, as you state, those recommendations were not taken forward at that point while the grievance process ran.

15:10

161 Q. You are not suggesting that the instigation of a grievance process would have prevented the Trust from monitoring the activity of a clinician who was causing concern?

A. My understanding, and as I've commented on with regards to how that monitoring was being done, the monitoring arrangements that were instigated in early 2017 on return to work continued during that process. It wasn't that no monitoring happened, but the monitoring continued from a Trust perspective in the same way as it had done since early 2017.

15:10

15:10

162 Q. Yes. This recommendation from Dr. Khan was calling for a new action plan with monitoring, one that, to quote him, "must address any issues with regards to patient related administrative duties". We will obviously speak to Dr. Khan in due course, but he seemed to be contemplating a revised plan that might indeed be broader, go into areas of administrative duties in connection with patients that weren't perhaps caught by

15:11

1 the earlier plan. When you saw this, saw a role for  
 2 you within it, did you ask questions wearing your AMD  
 3 hat about why aren't we doing this?

4 A. As I have said, I can't remember specifically today  
 5 when I saw this. My memory is it was much, much later 15:12  
 6 in this process, coming well into 2020 that I became  
 7 aware of and saw the whole report. By this point,  
 8 concerns were still being raised and taken forwards at  
 9 that time. We didn't have, as you say, a specific  
 10 action plan wasn't developed but there were additional 15:12  
 11 concerns being raised.

12 163 Q. Just so that the Inquiry has it as clear as it can.  
 13 This report, signed off by Dr. Khan, presumably goes to  
 14 the Medical Director's office and whoever else needs to  
 15 see it, but although you are the senior man in terms of 15:12  
 16 Governance within the Surgical and Elective Care part  
 17 of Acute with responsibility for Urology and with  
 18 responsibility for this Clinician, you don't get to see  
 19 it at all until 2019/2020. It's not even discussed  
 20 with you? 15:13

21 A. I'm aware that he's been presented with the MHPS  
 22 report, but I'm not aware of the content of.

23 164 Q. It doesn't require hindsight and all that we are aware  
 24 of now, this should have been an important moment to  
 25 sit down with the report of Dr. Chada, the 15:13  
 26 determination that emerged from it, from Dr. Khan and  
 27 for discussion between you and the Medical Director and  
 28 perhaps Dr. Khan to work out what needs to be done,  
 29 what can be done, notwithstanding the grievance?

1           A.    Yeah, there was an opportunity there where a more  
2                comprehensive action plan could have been developed  
3                that may have picked up issues that were found at  
4                a later date.

5   165   Q.    Yes.  You've acknowledged that you had the concern that   15:14  
6                this was a Clinician who presented as a Patient Safety  
7                risk.  You have confirmation of that from all that you  
8                are aware of through the Incident Reports, the MHPS  
9                report.  Was there not a suspicion that there must be,  
10              or at least there may be, more hidden in a dark place   15:14  
11              that's yet to be exposed, that we ought to be going  
12              looking for, that the MHPS report is perhaps only the  
13              tip of the iceberg?

14           A.    Certainly reading the MHPS report and the comments  
15                within there, not only about the ways of working but   15:15  
16                also about the insight demonstrated, should have raised  
17                a flag that there would be other concerns within  
18                practice, and other concerns that needed addressing.

19   166   Q.    The action plan that was in place, if we could turn it  
20                up, please, at TRU-00732.                           15:15

21           CHAIR:  Sorry, Mr. Wolfe, while that's being called up  
22                I am just wondering if people require a break or if  
23                they are content to sit on.  I see from Mr. Lunny --

24           MR. LUNNY KC:  I am perfectly content to sit on but one  
25                observation I would make the break does facilitate,   15:16  
26                even if it's only five minutes, it allows us an  
27                opportunity sometimes to speak to Mr. Wolfe to say  
28                there's another page on that e-mail, for example, that  
29                you should perhaps bring up, rather than leave it to

1 the 13th December or phase 2, as it were.

2 MR. WOLFE KC: okay.

3 CHAIR: Is this an appropriate point then, Mr. wolfe?

4 MR. WOLFE KC: Yes.

5 CHAIR: Okay. Let's say ten minutes, Mr. Lunny.

15:16

6  
7 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

8  
9 CHAIR: Mr. wolfe, just before you start, I don't think  
10 we should sit any later than half past four, in ease of 15:27  
11 Mr. Haynes and everyone else. I think it's been a long  
12 enough day.

13 MR. WOLFE KC: I think we are coming back on another  
14 occasion, I may even stop shortly after 4:00, if that's  
15 okay. 15:27

16 CHAIR: That's fine. Thank you.

17 MR. WOLFE KC: I don't hear any dissent.

18 167 Q. we have up on the screen, just show the witness the  
19 first page of it, please. This is the Return to Work  
20 Plan with monitoring arrangements following a meeting 15:27  
21 on 9th February 2017. That's at the very start of the  
22 MHPS process, Mr. Haynes. Clearly, by that stage, you  
23 weren't in your AMD role and you would not have been  
24 cited on that, I rather suspect. You've told us,  
25 I think, that you first became aware of the action 15:28  
26 plan, and we will go to the e-mail presently, but it  
27 appears to be towards the end of 2018, about a year  
28 after you took up the AMD role, but we will look at  
29 that. what I want to ask you about in this sequence is

1 about your view of the adequacy of the plan going  
 2 forward from a position in October 2018 when MHPS is  
 3 reported. You are not, you say, familiar with the  
 4 outcome of maps at that point. With those caveats in  
 5 mind, could we scroll down and just look at the various 15:29  
 6 aspects.

7  
 8 Concern 1, at the bottom of the page, was in respect of  
 9 patient referrals, in other words Triage:

10 15:29  
 11 "All referrals received by Mr. O'Brien will be  
 12 monitored by the Central Booking Centre..."

13  
 14 The standard against which Mr. O'Brien will comply, at  
 15 the top of the page, is that "all referrals must be 15:29  
 16 completed by 4 p.m. on the Friday after Mr. O'Brien's  
 17 Consultant of the Week ends. Red Flag referrals must  
 18 be completed daily."

19  
 20 Does that seem an adequate standard to hold the 15:29  
 21 Urologist of the Week to, in this case Mr. O'Brien?

22 A. I think it's an adequate aspiration. I think if I were  
 23 writing that, I would allow a caveat for a particular  
 24 -- you could have a particularly busy day where you may  
 25 not get to this. You may have a day where you are 15:30  
 26 called in through the night previously and, therefore,  
 27 don't perhaps meet that Red Flag completed daily  
 28 because of fatigue and workload.

29 168 Q. Yes.

- 1 A. You have to have a caveat recognising that where it's  
2 attached to an unpredictable emergency workload, there  
3 has to be some tolerance.
- 4 169 Q. Yes. Scrolling down to concern 2, which is the  
5 retention of notes in office or in home. 15:30  
6
- 7 "The standard to be applied is that Mr. O'Brien is not  
8 permitted to remove patient notes off Trust premises.  
9 Notes tracked out to Mr. O'Brien must be tracked out to  
10 him for the shortest period possible for the management 15:31  
11 of a patient. Notes must not be stored in  
12 Mr. O'Brien's office. Notes should remain located in  
13 Mr. O'Brien's office for the shortest period required  
14 for the management of a patient."  
15 15:31
- 16 Again, does that seem reasonable and comprehensive?
- 17 A. It seems reasonable. To me, either explicitly within  
18 it or behind this needs to be a process for how notes  
19 are to be taken to the Clinics in South West Acute  
20 Hospital. 15:31
- 21 170 Q. Yes. Concern 3 then is issue of dictation. It says:  
22
- 23 "All clinics must be dictated at the end of each  
24 clinic/theatre session via digital dictation. This is  
25 already set up in the Thorndale Unit and will be 15:32  
26 installed on the computer in Mr. O'Brien's office and  
27 on his Trust Laptop. This dictation must be done at  
28 the end of every clinic and a report via digital  
29 dictation will be provided on a weekly basis to the

1 Assistant Director of Acute ... to ensure all outcomes  
2 are dictated.

3  
4 An outcome/plan/record of each clinic attendance must  
5 be recorded for each individual patient and this should 15:32  
6 include a letter for any patient who did not attend as  
7 there must be a record of this back to the GP."

8  
9 Again, does that seem both reasonable and  
10 comprehensive, or if you were writing this with the 15:32  
11 benefit of what you know now, would you extend it?

12 A. It seems reasonable. With the benefit of hindsight  
13 I would extend it. As we perhaps found later, while  
14 there may be the required number of dictations at the  
15 end of a clinic session, that didn't always mean that 15:33  
16 there was a letter done on every patient. So there  
17 needed to be a second step where the patients  
18 themselves, their record was assessed to check that  
19 there was a letter on every patient attending. I think  
20 that in terms of monitoring it, I think there should 15:33  
21 have been a greater involvement in the person  
22 closest --

23 171 Q. Let me see what's over the page, it doesn't appear to  
24 -- it provides for a report via digital dictation. Is  
25 that check? 15:34

26 A. Essentially that was a manual check of is there  
27 a dictation on the digital dictation system for the  
28 number of patients who attended. The staff member  
29 closest to this within the Trust is always going to be

1 the secretary doing the typing, and there isn't a role  
 2 within this of that reporting. As I described earlier,  
 3 with regards my practice and my secretary as a safety  
 4 mechanism for me, should be reporting if I'm not doing  
 5 something and that would apply here.

15:34

6 172 Q. Yes. This Concern 3 appears to have its context in the  
 7 dictation of Outpatient outcomes, or Outpatient  
 8 encounters. Therefore, given what was known by the  
 9 date of the report of MHPS or, in the alternative,  
 10 given the kinds of suspicions that might have arisen in  
 11 light of the outcome of MHPS, should this kind of  
 12 monitoring of dictation have been broader than simply  
 13 Outpatients?

15:35

14 A. I think the monitoring of his activity should have been  
 15 much broader and included the other aspects that we've  
 16 identified, like the results.

15:35

17 173 Q. You could think of many examples?

18 A. Yeah.

19 174 Q. You could think of, given what we know from 2020 and  
 20 indeed some of the SCRR cases that have been reported  
 21 into the system; the complaint, at least from the Trust  
 22 perspective, and I realise Mr. O'Brien may not share it  
 23 so I will put it in these terms. There appear to be  
 24 a suspicion on the part of the Trust that he wasn't  
 25 dictating following Multidisciplinary Meetings?

15:35

26 A. You wouldn't necessarily dictate after  
 27 Multidisciplinary Team Meetings, so the CAP system  
 28 which is the system used to record Multidisciplinary  
 29 Team Meeting discussions and outcomes generates an

15:36

1 automatic letter to GPs. We wouldn't always be  
2 dictating a letter for every patient discussed at  
3 a Multidisciplinary Team Meeting. Many of them  
4 outcomes would be to bring a patient back to clinic and  
5 it would be at that consultation where you would expect 15:36  
6 a letter or a referral to be dictated. I think one of  
7 the concerns about the Multidisciplinary Team Meetings  
8 as well as the not dictating the letters on the  
9 consultations, is the not following through the  
10 recommendation of the Multidisciplinary Team Meeting in 15:37  
11 the subsequent consultation.

12 175 Q. If you follow through the recommendation that should  
13 give rise to a dictated letter, shouldn't it, in terms  
14 of the referral? I mean, it's perhaps a slightly  
15 different point, I will grant you that, but it's of the 15:37  
16 species.

17 A. The consultation, irrespective, should generate  
18 a letter, and that letter should detail the action that  
19 should either match the Multidisciplinary Team Meeting  
20 or provide a reasoned explanation as to why it doesn't 15:37  
21 match that Multidisciplinary Team Meeting and that may  
22 be a patient choice that they decide they don't want to  
23 follow that recommendation.

24 176 Q. Yes. I suppose under the broad heading of  
25 administrative-type actions with impact on Clinical 15:38  
26 practice and Patient Safety, you, or Dr. Khan more  
27 particularly, could have imagined, at the end of 2018,  
28 a range of different administrative actions who were  
29 not-too-distant cousins from the kinds of shortcomings

1 exposed by the MHPS report, which should have found  
2 their way into an improved monitoring arrangement?

3 A. Yeah. If you are not dictating after a clinic, then  
4 there's 668 patients without an outcome formally  
5 dictated there are described there, could one of them  
6 have required a referral to another Speciality?

15:39

7 177 Q. Yes. If you were to have sat down, or Dr. Khan and  
8 others were to have sat down and developed a new action  
9 plan, it would have had similar pillars to this but it  
10 would have had a broader remit in terms of the areas of  
11 Administrative/Clinical practice that were worthy of  
12 scrutiny?

15:39

13 A. A broader remit and perhaps a clearer mechanism by  
14 which that is going to be monitored that's ensuring the  
15 actual intended outcome is monitored.

15:39

16 178 Q. Yes. The fourth Concern, over the page, concerns  
17 private patients and it refers to the Trust's private  
18 practice policy. It goes on to say that:

19  
20 "The scheduling of patients must be undertaken by the  
21 secretary, who will check the list with Mr. O'Brien and  
22 then contact the patient for their appointment. This  
23 process is in keeping with the practice established  
24 within the Urology team."

15:40

25  
26 That was the monitoring provisions and the standards  
27 which Mr. O'Brien was to be measured against. They, as  
28 you understand it, continued in place from February '17  
29 all the way through to his retirement in July 2020. Is

15:40

1           that right?

2           A.    Yeah.

3   179   Q.    You've said in your witness statement -- just for the  
4           record, I don't need to bring it up -- at WIT-53944,  
5           it's paragraph 66.1, that you were not part of the           15:41  
6           monitoring of Mr. O'Brien after MHPS. I think you have  
7           earlier explained that the indication that you  
8           shouldn't be involved came through the Medical Director  
9           at one point in time, Dr. Wright, but by this stage,  
10          I think, the end of 2018, Dr. Khan had assumed the role   15:42  
11          in an acting capacity, and the post of Medical Director  
12          was then to shortly pass on to Dr. O'Kane in, I think  
13          either the late part of '18 or early '19. Were they  
14          all similarly content that you would stay outside the  
15          formal role of monitoring?                                   15:42

16          A.    I don't recall a specific discussion about my role  
17          within that monitoring plan that was there.  
18          Dr. O'Kane, when she took over as Medical Director,  
19          very quickly involved me to a much greater extent in  
20          discussions and planning around the monitoring and           15:42  
21          oversight of Mr. O'Brien.

22   180   Q.    Yes. I'm interested in that distinction. You said you  
23           weren't involved in monitoring, but the Medical  
24           Director brings you in and you have a degree of  
25           involvement, which I hope to illustrate briefly before   15:43  
26           we finish today. What is the distinction that's being  
27           drawn? I can see through this e-mail correspondence  
28           that you're frequently made aware of deviations from  
29           the monitoring plan and frequently commenting, but not,

1 as it might appear, taking any particular managerial  
2 steps; is that fair?

3 A. When I was commenting on the action plan, my  
4 understanding of the escalation within there was it  
5 escalated through to Dr. Khan as the Case Manager. 15:44  
6 where I was commenting on the shortfalls of what I saw  
7 was being utilised for monitoring, I was escalating  
8 that through to Dr. Khan, who, as I understood it, was  
9 the Case Manager for this.

10 181 Q. One of the concerns that seems to be oft repeated in 15:44  
11 the e-mails is a concern about the reliability or,  
12 perhaps, the robustness of the data being relied upon,  
13 particularly in or around the issue of dictation. If  
14 I could just draw your attention to and have your  
15 comments on an e-mail I think you sent as far back as 15:44  
16 June '17 before you became AMD, WIT-55743. You are  
17 responding to the fact that Marie Evans has sent around  
18 something, I think it's called a Backlog Report, and  
19 your concern appears to be that this doesn't provide  
20 a true reflection of the extent of dictation activity 15:45  
21 on the part of Consultants feeding through to their  
22 secretaries. It gives a false impression. First of  
23 all, have I correctly diagnosed the problem, and what  
24 was it that was preventing the real picture from  
25 emerging using the backlog reports? 15:46

26 A. So my specific concern related to results, so scan  
27 results much like we have covered earlier, and how the  
28 column which was results to be dictated was being  
29 populated. We've covered that I had a suspicion,

1 a concern that Mr. O'Brien was not on top of his  
2 administrative processes, and yet what I saw in the  
3 Backlog Report was very often a report of no results to  
4 be dictated. I had multiple concerns with that. First  
5 of all, I didn't have a clear understanding of how that 15:47  
6 number was being generated; what were our secretaries  
7 being told to look at in order to generate this results  
8 to be dictated number? I had a very clear idea as to  
9 how my secretary was doing it, but I didn't have an  
10 understanding as to what instruction had been given to 15:47  
11 the secretarial team in terms of how that number was to  
12 be populated, and I guess the purpose of that report.  
13 I also had a concern that, in sending this round,  
14 seemingly giving us assurance that everything was okay,  
15 that our secretarial teams would somehow be culpable 15:48  
16 through perhaps a lack of guidance or a lack of  
17 understanding as to the importance of the Backlog  
18 Report in a broader scheme of things, they'd somehow be  
19 responsible for under-reporting activities not  
20 happening. What I was trying to ask was how are we 15:48  
21 generating this number? Is it a re-produceable number?  
22 Are the people who are providing this report aware of  
23 the importance of accurate data? Without them things  
24 being clear to me, and potentially to those who are  
25 generating it, how can this report in any way be 15:49  
26 a reliable monitor of anything?

27 182 Q. Your focus in this context, and you can see that, you  
28 are raising the alarm in a very particular context.  
29 What if a disaster happens and the data being produced

1 shows everything in the garden is rosy, it would be  
2 a dark day for those providing the data I suppose is  
3 what you are saying, so let's get it right. Do these  
4 Backlog Reports have a read across to other areas of  
5 dictation?

15:49

6 A. They include not only results -- the Backlog Report  
7 serves, I guess, a number of purposes. Some of the  
8 purposes it serves relate to a Clinician's actions, so  
9 the results to be dictated, Clinics to be dictated,  
10 discharge notes to be dictated. Some of them relate to 15:50  
11 secretarial and typing, so staff workload, so letters  
12 to be typed, so there's a dictation done but it's not  
13 typed. In order to use that in any way to monitor  
14 workloads, pressures, performance, each column we need  
15 to have a clear understanding as to where we get that 15:50  
16 data from and who is providing that data.

17 183 Q. I introduced that issue for your comment before looking  
18 at the next two years up to 2020, because it's my  
19 understanding that that Backlog Report, in substantial  
20 part, was the focus of Mrs. Corrigan's attention when 15:51  
21 monitoring Mr. O'Brien's dictation output?

22 A. That's my understanding, within the Backlog Report it  
23 was included a column for clinics to be dictated.

24 184 Q. Yes. I think that was her focus, on clinics being  
25 dictated. As we observed earlier, if you were 15:51  
26 rewriting that action plan, it would have a lot broader  
27 than that. Leaving that to one side, we will see that  
28 it at various points in the period after October 2018,  
29 you come in with observations about the reliability of

1 the data. At various points then, Mrs. Corrigan is  
2 communicating with you, and other members of the  
3 management team, pointing out deviations from the  
4 action plan observed by her on monitoring. Starting  
5 even before the MHPS report issues, so 23rd January 15:52  
6 2018. If we could pull up very briefly TRU-275133.

7 If we look at the bottom of the page first. Vicki  
8 Young is telling you, amongst others, the Red Flag  
9 Appointment team have brought to her attention there  
10 are seven referrals dating back from 18th January '18 15:53  
11 that need to be e-triaged and would it be possible to  
12 get those done today?

13  
14 Then scrolling up, you speak through this e-mail to  
15 Martina Corrigan: 15:53

16  
17 "Do you need to have a word?"

18  
19 You say before that:

20  
21 "I did 3 or 4 from the 18th yesterday." Were they your  
22 own? Was that your own workload catching up?

23 A. The way e-triage works is when you open the system,  
24 they are not assigned to a single Consultant. They  
25 will appear for Urology on every Consultant Urologist's 15:54  
26 ECR if they open the e-triage. I presume on that day  
27 I had either been on to the system because I was  
28 Urologist of the week, or I was on to the system to  
29 check if any had specifically been assigned to me. If

1 a referral comes into the Urology Department and it's  
 2 a patient who I have seen before or have some knowledge  
 3 of, then my colleagues can assign that to me and my  
 4 name appears next to it, it doesn't disappear from the  
 5 system for other people but my name is there for me to 15:54  
 6 look at it. Periodically, during a normal working week  
 7 I will have a check of the Triage system to see if any  
 8 have been assigned to me.

9 185 Q. Where you say there "do you need to have a word?"  
 10 directed to Martina Corrigan, what's that suggesting? 15:55

11 A. I presume it's do you need to have a word with,  
 12 I presume, Mr. O'Brien, about -- to catch up with it.  
 13 There is another, if you like, slight quirk of the  
 14 system, in that, if a patient needs registration on the  
 15 system, the referral letter doesn't appear on the 15:55  
 16 e-triage system the minute the GP presses refer on the  
 17 clinical communications gateway, which is the system  
 18 that the referral is generated on. I don't fully  
 19 understand what the process is, but there can be  
 20 a process, there is a process that's needed sometimes 15:55  
 21 for some patients before that can translate then over  
 22 to the e-triage system and on ECR. There are occasions  
 23 where a referral letter might have been sent, and it  
 24 will still be dated the 18th, but it doesn't appear on  
 25 the system until that process in the background has 15:56  
 26 happened, and then it will come up but still with the  
 27 date of the 18th.

28 186 Q. Thank you for that. If you are right and if this is  
 29 a slippage from the action plan arrangements, it's

1 coming to you via Mrs. Corrigan or via the coordinator,  
2 and you are pushing it off to Mrs. Corrigan. It  
3 doesn't seem to be going to Dr. Khan, who, as Case  
4 Manager within the MHPS and the associated monitoring  
5 arrangements, is the person who should be getting the 15:56  
6 deviations?

7 A. I don't think this e-mail at the bottom from Vicki  
8 Graham is, in fact, generated as part of the monitoring  
9 at all. It's been written to all of the consultants  
10 working at the time. Martina Corrigan isn't included 15:57  
11 in that circulation. Vicki Graham worked within our  
12 cancer team, and so she was working within that role  
13 and saying that there were Red Flag referrals and just  
14 raising it to us as a team in general.

15 187 Q. Yes. My point, sorry, maybe inelegantly expressed, is, 15:57  
16 if there is slippage from the standard that Mr. O'Brien  
17 is expected to comply with, with respect to Triage,  
18 Mrs. Corrigan obtains that information from the Red  
19 Flag team and if she's satisfied that there has been  
20 a deviation, she will be escalating it to Dr. Khan. Is 15:57  
21 that what she should have been doing with this  
22 information?

23 A. That's my understanding. My understanding is also that  
24 there was -- I mentioned when we talked about that  
25 return to work monitoring, that there needed to be some 15:58  
26 caveat for a busy period of on-call, that expecting  
27 everything to be done all the time, while an aspiration  
28 for it to be done within a day is reasonable, there  
29 needs to be a caveat of, if you like, a slightly

1 extended deadline if there are issues. My  
2 understanding is that there was a caveat introduced  
3 that altered that expectation from the original to  
4 a slightly, you know, not leaving it for a number of  
5 weeks but giving a few days' leeway for recognising 15:58  
6 busy periods would affect ability to maintain.

7 188 Q. Okay. So the suggestion have a word is, find out  
8 what's going on here?

9 A. Yes.

10 189 Q. And emphasise the need to get it done? 15:58  
11 A. Yes.

12 190 Q. Okay. The next occasion when Triage remains an issue  
13 is a week later, and I wonder is it part of the same  
14 sequence of events. If we can go a few pages further  
15 on to TRU-275138. Is there 1st February e-mail on 15:59  
16 down? Yes. This is Mr. Carroll's response, just above  
17 that.

18 CHAIR: Mr Wolfe, it looks as though Mr. Haynes has  
19 forwarded the original e-mail to Mr. Carroll, who then  
20 contacts Ms. Corrigan and says do we need to speak 16:00  
21 about this. Is that interpretation fair?

22 A. That's what I could see from the scan up and down.  
23 I forwarded it on to Mr. Carroll and Mr. Carroll has  
24 said to Martina, we need to pick this up on Monday.

25 191 Q. MR. WOLFE KC: Yes. And they schedule a meeting? 16:00  
26 A. I didn't catch that as we scanned up.

27 192 Q. If we can turn then to WIT-55772. Here again you are  
28 part of the team being advised by Vicki Graham that  
29 there are quite a few Red Flag referrals that are

1 outstanding dating back to the 4th October (36 in  
2 total).

3  
4 Again, how would you have responded to that as the AMD?  
5 Is that something that you would refer to  
6 Mrs. Corrigan?

16:02

7 A. As I have said, within the team on the Triage  
8 everything appears there for us to see. What I don't  
9 know is who was on-call at that time and I don't know  
10 what the busyness of the on-call at that time was.  
11 Generally, these sorts of e-mails we would endeavour as  
12 a team to try and pick up and get things done. Indeed,  
13 certainly from a personal perspective, and recognising  
14 that workloads during an acute week do vary, I didn't  
15 follow Mr. O'Brien on an on-call week, but if my  
16 colleague the day before had had a busy day and there  
17 were referrals waiting to be triaged, I would have  
18 picked them up and done them when I came on, if I was  
19 able to.

16:02

16:02

20 193 Q. During that period of time Mrs. Corrigan was absent  
21 from work for personal reasons, and an issue came to  
22 your attention about the absence of monitoring during  
23 her period away from work. If we can bring up the  
24 e-mail at TRU-258911. On 18th October, it was  
25 indicated to the system that Mr. O'Brien has  
26 accumulated a large backlog of dictated letters,  
27 a large number of charts in his room. Mr. Weir is  
28 saying that he hasn't seen the review and results of  
29 recommendations into his practice but he is assuming he

16:03

16:04

1 is in breach of the findings and he is asking Dr. Khan  
2 how he should proceed. Just go up the page.  
3 Mr. Gibson is employed in the Medical Director's  
4 office, is saying to Mr. Carroll:

5  
6 "What is most concerning here is that there were  
7 monitoring and supervision arrangements put in place,  
8 which we confirmed to a range of interested parties.

9  
10 If he has a Backlog of Clinic Letters and discharges  
11 going back to June, have these arrangements fallen  
12 down?"

13  
14 The next e-mail up, please. Mr. Carroll, somewhat  
15 tersely, says:

16  
17 "I think you are stating the obvious. With Martina  
18 having been off since June, the overseeing function has  
19 not taken place and the day-to-day activities was  
20 overlooked, but we need to understand why the dictation  
21 has gone out, this could explain the volume of notes or  
22 there may be some other reason."

23  
24 Then Mr. Haynes replies to Mr. Carroll:

25  
26 "According to Simon" -- Simon Gibson, that is -- "there  
27 were monitoring and supervision arrangements put in  
28 place, which we confirmed to a range of interested  
29 parties..."

1  
2 You make the point that you have been making earlier:

3  
4 "I wasn't one of these interested parties, neither from  
5 Colin's e-mail was he, or Michael from his." 16:06

6  
7 That's Michael Young.

8  
9 "So if the Clinical Lead in the Service, the Clinical  
10 Director and the Associate Medical Director weren't, 16:07  
11 I'm not sure who was.

12  
13 I can only assume, given the Trust's previous failings  
14 in tackling behaviours in this case, the arrangements  
15 were robust, regularly monitored at multiple levels and 16:07  
16 had clear back stops for sickness so that it wasn't  
17 reliant upon only Martina?"

18  
19 Just to unpack that a little. That's you telling  
20 Mr. Carroll that, if I have got the tone right, you are 16:07  
21 not best pleased that you weren't informed of what the  
22 monitoring arrangements amounted to, or that they even  
23 existed?

24 A. I think it's me saying that it's not clear to me who  
25 was involved, what the arrangements were and, as I've 16:07  
26 suggested, it appears that they've been reliant on one  
27 individual, which is an inherent weakness in the plan  
28 that had been made.

29 194 Q. Yes. But surely there's also saying that I should have

1           been involved, I should have been at least told of the  
2           existence of these arrangements?

3           A.   Or absolute clarity as to who was told and where that  
4           fitted within the existing management structure.

5   195   Q.   You set that against the background, as you put it very   16:08  
6           candidly, of the Trust's previous failures to engage in  
7           ineffective monitoring and the need for the monitoring  
8           going forward to be robust. If it's dependent upon one  
9           person and not picked up upon by others in her absence,  
10          are you saying that you struggle to see how it could be   16:09  
11          considered to be robust?

12          A.   I think, as I have said previously, if you haven't got  
13          clarity as to how monitoring is being performed, how  
14          the data that's being utilised for monitoring is being  
15          obtained and clarity as to who and how and where cover   16:09  
16          provides, then you haven't got a robust process. If  
17          your robust process involves someone doing the  
18          monitoring themselves without a clear description that  
19          can be picked up by someone else in their absence, then  
20          your process has an inherent frailty.                           16:09

21   196   Q.   This is the 18th October 2018. MHPS has just reported,  
22           or is about to, in the sense of Dr. Khan's  
23           determination. As we have observed earlier, it  
24           provided for the development and formulation of a new  
25           action plan, and you have explained that that wasn't,   16:10  
26           at that point, known to you. But knowing that there  
27           was this monitoring plan in place as a result of these  
28           e-mails that had come to you, is that the point where  
29           you sourced the extant action plan and got to know what

1 it was doing?

2 A. I don't have a recollection, but clearly I've expressed  
3 significant concerns in the way monitoring was being  
4 undertaken.

5 197 Q. But you don't have a recollection of doing anything 16:11  
6 specifically to bottom out how this was being done and  
7 what was being monitored?

8 A. I think I've asked in that e-mail -- well, I haven't  
9 asked but I've made a statement to Ronan, who was  
10 involved in the monitoring process, that I'd concerned 16:11  
11 about how that process was being undertaken and how  
12 robust it was. I can't recall what followed that  
13 e-mail.

14 198 Q. There certainly wasn't a step into the arena of looking  
15 at the extant action plan and reformulating it in any 16:11  
16 way to make it better?

17 A. I don't recall that.

18 199 Q. I will put it another way. This was an opportunity,  
19 given your responsibilities as AMD, to have, now that  
20 you're informed of it, to say, well this isn't good 16:12  
21 enough, look at what we know about Mr. O'Brien. We  
22 should expand this action plan and associated  
23 monitoring into other areas; the point is, that wasn't  
24 done?

25 A. Yeah. I think I've said that, but I haven't taken it 16:12  
26 that step forwards.

27 MR WOLFE KC: Okay. I think, Chair, this would be  
28 a convenient point.

29 CHAIR: Just because we won't see you until a later

1 date, Mr. Haynes, if you don't mind we would have a few  
2 questions that we'd like to ask you now, and hopefully  
3 we will not keep you much longer beyond the half past  
4 four. Mr. Hanbury, maybe I will ask you to go first  
5 this time.

16:13

6  
7 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL  
8 AS FOLLOWS:  
9

10 MR. HANBURY: Thank you for coming. I have just got  
11 one question about the MDT process, the MDM process,  
12 the preparation, your Department had a arrangement that  
13 one of the clinicians would take on the preparation,  
14 the preparation and the mop-up afterwards, which is  
15 quite intensive and time consuming. Why did you do  
16 that rather than everyone sharing the work out on the  
17 day?

16:13

16:13

18 A. So, other MDTs would have processes where the clinician  
19 who has seen the patient presents the patient, and one  
20 of the inherent weaknesses in that is if a clinician  
21 isn't present then a patient's care doesn't get  
22 discussed. From before I worked in Southern Trust  
23 there was a working pattern within the Urology  
24 Multidisciplinary Team Meeting where that wasn't the  
25 process that was utilised, but the Chair of the meeting  
26 presented the cases, which meant that patients would  
27 pass through the Multidisciplinary Team Meeting,  
28 whether or not the Clinician who had seen the patient  
29 was present. That landing on the shoulders of a single

16:13

16:14

1 person is a significant workload and so, with the  
 2 expansion of the team, and particularly given, say, my  
 3 interests which have always been on an Oncology bent  
 4 that we made a decision to rotate that Chair  
 5 responsibility so it reduced that workload, so each of 16:14  
 6 us took it in turns to take that on. When  
 7 Mr. O'Donoghue joined us in August that became us  
 8 taking it on on a sort of rotational one in four basis.  
 9 DR. SWART: You have described quite clearly taking on  
 10 the AMD role when you had very extensive clinical 16:15  
 11 responsibilities, including outside the Southern  
 12 Healthcare Trust, and it's obvious that was  
 13 a considerable challenge. What was it that motivated  
 14 you to want to take that role on at that time?

15 A. I think it's the same thing that motivates many of us 16:15  
 16 who make decisions to take on additional roles outside  
 17 of our, if you like, our core Consultant  
 18 responsibility, and that's a desire to work to improve,  
 19 and improve both the working arrangements and the  
 20 service received by patients. So that's the desire. 16:15

21 200 Q. You also said that you didn't have any induction or  
 22 handover. Was any support offered to you by the Trust  
 23 at the time you took the role on?

24 A. I don't recall.

25 201 Q. Did you ask for any? 16:16

26 A. Probably not.

27 202 Q. I'm specifically thinking of whether you thought it  
 28 would be a good idea to go and talk to the Medical  
 29 Director about mentoring or any other senior colleague

1 input?

2 A. I was Clinical Director at the time so I had met the

3 Medical Director on a number of occasions through that.

4 203 Q. Yes.

5 A. I had, if you like, a direct line into the Medical 16:16

6 Director already at that point.

7 204 Q. Did you have any discussions with other AMDs and CDs

8 about the challenges of this combination of clinical

9 responsibility and managerial role, and did you come up

10 with any ideas about things that would improve the 16:16

11 situation for you?

12 A. I don't recall any specific conversations about that.

13 205 Q. Another thing you talk about is this tension, which is

14 clearly very real in terms of being a colleague in

15 Urology and being AMD at the same time. Again, did 16:17

16 anybody talk to you about how you might want to handle

17 that in the circumstances you found yourself in?

18 A. No.

19 206 Q. Okay. Just lastly, you talk about the desire to make

20 improvement. You describe some improvements in your 16:17

21 own practice, which would have general application

22 across the Trust in terms of the quality improvement in

23 processes, I am talking about results and also some of

24 your Triage. Do you feel as AMD you were empowered to

25 kind of spread those improvements or that you had 16:17

26 access to quality improve resource? What's your stance

27 on that?

28 A. We had access to quality improvement resource and,

29 within the evidence bundles we had an adept fellow join

1 the Trust and do a project on the Stone Service within  
 2 urology, so we had access to quality improvement  
 3 projects. In terms of them patterns of working, we  
 4 would have communicated regularly just within the  
 5 Consultant team as to how and what we were doing and, 16:18  
 6 you know, I am, in the context, an early adopter, so  
 7 once I was aware of the existence of something I looked  
 8 to take it on, and tried to encourage people to take it  
 9 on. If we look at, like, the sign-off and results,  
 10 that is included in a number of SAI recommendations and 16:18  
 11 that would have been discussed at Acute Clinical  
 12 Governance, and I was a strong proponent of this being  
 13 rolled out and taken on by teams across the Trust.  
 14 Unfortunately, from many there was often a resistance  
 15 to this, seeing it as a significant increase in 16:19  
 16 workload, and not necessarily believing my perspective  
 17 that it made it easier.

18 207 Q. Are you telling me you felt more barriers than  
 19 empowerment at that particular point?

20 A. I think the barriers were people not wishing, 16:19  
 21 individuals not wanting to change the way that they did  
 22 things, yeah.

23 208 Q. Okay.

24 CHAIR: Thank you. I suppose mine is less of  
 25 a question and more of a comment. I find it 16:19  
 26 surprising, we have talked about the delay in reporting  
 27 on SAIs, the whole purpose of an SAI investigation is  
 28 to learn and to learn quickly and to improve Patient  
 29 Safety, and I found it surprising that there was no

1 deadline set for delivery of an investigation. You  
 2 described how it was difficult to find time for the  
 3 team to get together to discuss matters. In my  
 4 experience of other professions, and I speak obviously  
 5 of the legal profession of which I would know best, but 16:20  
 6 often meetings such as that would take place outside  
 7 the working day to ensure that they happened and that  
 8 they happened in a timely way. Was that never an  
 9 option?

10 A. Of course that's an option, but I think, if I look at 16:20  
 11 my own practice and we look at the e-mail we had up  
 12 yesterday from late 2018, I detailed that I was already  
 13 using significant portions of time outside of the  
 14 normal day to do activity. From a personal  
 15 perspective, you are almost deciding what do you stop, 16:20  
 16 and that's where the earlier question as to, do I have  
 17 any recommendation comes. If we want to get this done  
 18 by a deadline, then we've got to decide what we don't  
 19 do to enable everyone to be able to attend. What are  
 20 we going to stop to make sure that every member of this 16:21  
 21 panel is present next Wednesday morning for a meeting?

22 209 Q. Or Wednesday evening?

23 A. Or Wednesday evening, yeah.

24 210 Q. I suppose was any consideration given to putting into  
 25 place locums to cover the work to allow you get the 16:21  
 26 SAIs done in a timely fashion?

27 A. I have touched on the challenge in terms of locum  
 28 appointments within my statement. As I have said in  
 29 the statement, while, on the face of it, it can seem

1 a straightforward solution, it can often end up  
2 actually creating more work than the problem that they  
3 have solved.

4 CHAIR: Thank you, Mr. Haynes. We will, unfortunately  
5 from your point of view, see you again. Thank you for 16:21  
6 attending both yesterday and today.

7 MR. WOLFE KC: Just one final point. I drew attention  
8 to the complaint, I think, registered by Mr. O'Brien  
9 when he was afforded only a couple of days to reply to  
10 the SAI concerning Patient 16. I think it's fair that 16:22  
11 I refer you to -- I don't need it brought up on the  
12 screen but just for your note -- an e-mail series  
13 starting at PAT-000119, which I think indicates that  
14 certainly while he was initially given a very short  
15 time frame to respond, and that came in the context of 16:22  
16 a three-year interval before it made its way to him, he  
17 was given, I think, several weeks to turn around his  
18 response in full, to put that in for fairness.

19  
20 I think what I will engage with Mr. Lunny and his team 16:23  
21 to see when we can get Mr. Haynes back to us. Probably  
22 half a day or a little more than that, I wouldn't  
23 imagine a full day.

24 CHAIR: Very well. We are not due to sit again to hear  
25 further evidence until the 29th, so we won't be sitting 16:23  
26 next week, and I will see you all again then on 29th  
27 November.

28  
29 THE INQUIRY THEN ADJOURNED TO 29TH NOVEMBER 2022